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# Residential Treatment of Emotionally Disturbed Children: Description And Follow Up Study

By

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Submitted to the Faculty of Graduate Studies and Research In Partial Fulfilment of the Requirements for the Degree of Master of Education.

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The undersigned certify that they have read and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled "Residential Treatment of Emotionally Disturbed Children: Description and Follow Up" submitted by L. Wayne Howard in partial fulfilment of the requirements for the degree of Master of Education.

## Abstract

The purpose of this study was to describe residential treatment of emotionally disturbed children and present follow up data aimed at assessing treatment "success" in addition to assessing the significance of pre-treatment, treatment and post-treatment variables as related to successful adaptation to the community following discharge.

The subjects were all graduates of Westfield Diagnostic and Treatment Centre in Edmonton, Alberta, fourteen years of age and over. A survey was designed and mailed to the graduates along with form H of the Mooney Problem Check List. Of 160 questionnaires sent 83 were returned.

Likert Scale ratings of adaptation variables, pre-treatment variables, treatment variables and post-treatment variables were used. Pearson Product-moment correlations were applied to examine four null hypotheses:

1. There were no significant correlations between family ties during treatment and adaptation at the time of survey.
2. There were no significant correlations between adaptation to the institution and post-treatment adaptation.
3. There were no significant correlations between institutional circumstances during treatment and adaptation at the time of the survey.
4. There were no significant correlations between situational factors following discharge and adaptation as indicated by the survey.

Findings of this study indicated a high degree of

treatment success measured in terms of successful post-treatment adaptation. Of graduates surveyed 77 percent were living in community placements. The remaining 23 percent were living in institutions for juveniles or adult offenders. Approximately 46 percent of these children were enrolled in community schools with the majority (approximately 16 percent) taking diploma or general school programs. Approximately 19 percent were not working or attending school.

Major post-treatment problems areas as identified by the Mooney Problem Check List included social-psychological relations, home and family, morals and religion, personal-psychological relations, and finances, living conditions and employment.

Overall correlations substantiated the four null hypotheses, however, a number of specific correlations were significant. The nature of situational factors after discharge were most predictive of post-institutional adaptation. Family involvement and extent of therapy in treatment was seen to be important in successful treatment of emotionally disturbed children as was the quality of staff-child relationships. Positive adaptation to the institution did not forecast adequacy in the post-institutional environment. The impact of the family situation prior to treatment was reflected in post-treatment adjustment at school and work. Students who had community school exposure before leaving the institution tended to adapt better to community school placements following discharge. Beyond a certain length of time institutional treatment had a detrimental effect in terms of later adaptation to the community.

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## Introduction

A popular musical recently shown in most North American theatres was based on a nineteenth century novel by Charles Dickens. Its name is "Oliver" and it has many happy songs. But it has its sad songs too, and one of these "Where is Love" (Sung by Oliver Twist) is a reminder of not only the plight of orphans and overworked children of Dicken's England, but of needy children everywhere - in those days and these.

In the nineteenth century, almshouses, workhouses, and orphanages were the chief answers to adults and children requiring community care, but around the turn of the century things began to look up for needy youngsters. Enlightened and interested persons learned of the importance of family contact for all children, however needy and the age of the great foster family movement was ushered in. Since then improvements in social development programs, adaption practices and protection services have alleviated many general types of child need.

Yet, while worthwhile gains have been made evidence has indicated that emotional disturbance is the most widespread and crippling of childhood diseases. In 1962 in its brief to the Hall Royal Commission, the Canadian Mental Health Association made what it called a very conservative estimate that between 5 and 10 percent of all children show signs of mental and emotional disturbance. By the time children reach adolescence the brief stated the percentage of those showing

emotional and social disturbance, ranging from psychotic behavior to those who have become disenchanted, alienated, hostile and full of fear will very probably have risen to about 15 percent. From these children come many of those who are delinquent. Dr. Angus Hood, director of the Toronto Mental Health Clinic, has stated that including thousands of children passing through temporary maladjustments, it is reasonable to say that of every class of thirty-five children six or seven need extra help for emotional adjustment.

The acuteness of the problem has been most recently outlined in One Million Children -the Celdic Report (1970) which stated:

> a) Twelve percent of the population up to nineteen years of age, or no less than a million children and youth in Canada today require attention, treatment and care because of emotional and learning disorders.
>
> b) In any other field, a problem of this magnitude would be heralded as an acute epidemic or a national disaster.
>
> c) We deplore the fact that the specialized clinic or specialist all too frequently assumes no responsibility for treatment and the parents are left to start their difficulty search again.
> (The Celdic Report, 1970).

## The Purpose of the Study

Whereas emphasis has been put on the need for increased treatment facilities for emotionally disturbed children, little evaluative research has been done on existing programs to determine their effectiveness and thereby set guidelines for future expansion of treatment facilities.

In the province of Alberta, Dr. W. R. N. Blair in 1968 conducted

a study designed as a critical examination of all provincial aspects of mental health services. The purpose of the study was to produce ideas and recommendations which would help improve services to the point where they would become comprehensive, integrated and adequate. In addition to calling for general treatment, coordination and unification of governmental departments involved in the treatment of emotionally disturbed children, the report described regionalization of existing services as most insufficient and outlined the following as essential for providing an adequate standard of care and treatment in a region--

a) a diagnostic and assessment service.

b) in-patient treatment facilities of a particular kind, including provision for education.

c) day-patient and out-patient treatment in association with special classes in the school system.

d) emergency service seven days a week.

e) supportive and rehabilitative services in the community.
(Blair, 1969)

Treatment and education of emotionally disturbed children and adolescents was described as requiring the provision of space, which is not always present at conventional hospitals and not necessarily requiring other costly hospital services. Suggested as a facility was a small cottage-type unit which as a part of an overall treatment complex could meet diagnostic treatment and educational needs of emotionally disturbed children.

The residential treatment model outlined in the Blair Report

was not totally new to the treatment scene of the emotionally disturbed in Alberta. In 1964 an Edmonton Diagnostic and Treatment Centre pilot project based on a concept of milieu treatment or therapeutic environment was initiated to meet regional diagnostic and treatment needs of children. Using the Westfield Edmonton Diagnostic and Treatment Centre* as a focus it was the purpose of this study to describe residential treatment of emotionally disturbed children, and present follow-up data aimed at assessing treatment effectiveness.

Statement of the Problem

It is uncertain what happens to the graduate of a treatment centre for the emotionally disturbed and what treatment components were significant to those who managed to adapt to community living.

Allerhand (1961) noted a marked temptation when considering directions for research in residential treatment to embark on a project to evaluate treatment results. He stated:

> there are many kinds of research one might undertake in a treatment institution but none engenders such immediate interest and curiosity among colleagues as a follow-up study .... one can immediately conjure up visions of demonstrating the effectiveness of a program or at least implying that it compares favorably with that of other institutions. (Allerhand, 1961, p.7)

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*The name was changed in the fall of 1972 from Edmonton Diagnostic and Treatment Centre to Westfield Diagnostic and Treatment Centre.

Current intake criteria, however, were found to be not precise enough to permit measured comparisons between settings. Also treatment "success" was found to be defined in various ways.

"Success" in residential treatment is one of the most elusive concepts to define and translate into researchable terms. Fanshel (1962) emphasized the uniqueness of each childs prognostic baseline from which change must be measured. Alt (1960) pointed to the speculative nature of appraisals of long term treatment results. He stated

> the progress of more of the cases can be adjudged a success or failure in any definitive sense. All have shown change in some aspect of their personality and behavior. Whether the positive changes will be lasting, whether these young people will be able to meet successfully, the problems of living which will confront them, whether the demands of new life situations will overwhelm them; or whether our work though meager in its immediate results, may still bear fruit in their later lives — these questions cannot be answered. (Alt, 1960, p. 305).

Although a child may show significant changes in intrapsychic adjustment one cannot categorize him successfully treated unless he can function in accordance with realistic expectations and societal standards. One might define adaptation as the degree to which individuals master external reality while achieving a sense of inner unity and continuity with society. The degree of adaptation would seem to be the most crucial indicator of treatment success.

Matsushima (1965) described the majority of cases typical of those admitted to residential treatment as lacking the development

essential to inner change. Thus in these cases he stated progress in treatment was liable to be strongly affected by the quality of family involvement during treatment and the institutional circumstances. In essence the environments ability to support a child and the quality of family ties were seen as being as significant as the child's characteristics in determining treatment outcome.

Progress or "success" was stated in terms of a total case modifiability, the treatment components of which included individual modifiability, family involvement and institutional circumstances.

Allerhand, Weber and Haug in their research in 1971 found that positive adaption to the institution did not forecast adequacy in the post institutional environment and pointed to the significance of situational factors after discharge as well as a need for community involvement during treatment and aftercare programs.

Methods and Procedure

In attempting to determine the degree of adaptation of graduates of Westfield Diagnostic and Treatment Centre, all graduates fourteen years of age and over as of June 1971 were chosen for a follow up study.

Subjects were selected from discharge records at Westfield and included 111 males and 49 females who were located using files from the central office of the Department of Health and Social Development.

Viewing "treatment success" in an adaptive sense, a survey was designed and mailed to graduates in an effort to relate pre-treatment variables, treatment variables and post-treatment situational factors with adaptation at the time of the survey.

Also administered was Form H of the Mooney Problem Check List in an effort to better assess the subject's post-treatment adaptation as well as identify common problems experienced by graduates of the Centre.

Hypotheses

As a result of inconclusive evidence relating existing motions of post-discharge adaptation with pre-treatment, treatment and post-treatment variables, and the contradictory definitions of treatment success, the hypotheses stated for the purposes of this study were in the form of null hypotheses.

The hypotheses to be tested for Westfield Diagnostic and Treatment Centre graduates included the correlations between adaptation as measured by:

a) residential setting at the time of survey.

b) school and/or work situation at the time of survey.

c) post-treatment self-assessment of adjustment and

d) problems as rated on the Mooney Problem Check List and variables probing:

i) pre-treatment situations

ii) family ties during treatment

iii) individual modifiability and adaptation to institution during treatment

iv) institutional circumstances

v) situational factors following discharge

The null hypotheses were stated as follows:

1) There were no significant correlations between family ties during treatment and adaptation at the time of the survey.

2) There were no significant correlations between adaptation to the institution during treatment and individual modifiability during treatment and post-treatment adaptation as indicated by the survey.

3) There were no significant correlations between institutional circumstance during treatment and adaptation at the time of survey.

4) There were no significant correlations between situational factors following discharge and adaptation as indicated by the survey.

Definition of Terms

Family Involvement: viewed in terms of wardship at time of admission, family stability as seen by the subject and involvement of the family in the treatment program.

Adaptation to the Institution: defined by response to the "color system" (described in Chapter III), formation of relationships with staff, emergence of feelings of guilt during treatment and utilization of treatment facilities and assimilation of treatment objectives.

Institutional circumstances: included type of residential setting, type of school setting, type of therapy exposed to peer influence and interaction and length of stay during treatment as assessed by the subject.

Situational Factors Following Discharge: included placements following discharge and self appraisal of problems experiences at home, in school and in the community following discharge.

Limitations of the Study

In addition to previously mentioned limitations of definition and approach to the problem of residential treatment of emotionally disturbed children and evaluation of its effectiveness, generalizations drawn as conclusions in this study were made in light of the following limitations.

In many follow up studies of this nature the response to a questionnaire-type survey is usually unfavorable, especially for those individuals having difficulty coping following discharge. Conditions of sample mortality and motivation to answer honestly, therefore, were limiting factors in such a research design. More specifically not included are those who could not be located or had moved since being located at the time the survey was mailed.

Instrument limitations constituted a third area of design weakness with a designed survey of this mature valid responses to some questions depended upon accurate memory of a past situation. Research, however, recently conducted by Allerhand, Weber and Haug (1966) has demonstrated that reports made by children regarding their treatment experiences were significantly accurate. Responses were checked with data available on files. In addition the Mooney Problem Check List has been constructed for a variety of purposes and offers no single index of validity or reliability. It can be concluded however that while problem check lists are designed to reflect changing situations and experiences in the individual case they nevertheless exhibit sufficient stability to warrant general program planning on the basis of survey results.

Organization of the thesis

Following the introduction of the nature and purpose of the thesis in Chapter I, a review of the literature related to emotionally disturbed children and treatment programs was discussed in Chapter II. Chapter III contained a discussion of the treatment program at Westfield Diagnostic and Treatment Centre. Chapter IV presented a description of the design of the study along with method and procedures of collecting data. The information gathered via questionnaires, files and Mooney Problem Check Lists was categorized and presented in Chapter V. Finally, a summary obtained from analyzed data and recommendations and implications for further research were presented in Chapter VI.

## Chapter II

## Review of Related Literature

### Introduction

The term emotional disturbance has been defined in many ways and has been used somewhat loosely by both professionals and members of the lay public. Various terms such as maladjustment, deviance, delinquency and behavior disorders have appeared frequently in the literature.

Cohen in her 1968 study of terminology, substantiated Kirk's (1962) suggestion that the way a behavioral situation was described was largely a function of the observers orientation. While a boy's parents might have regarded their son as being a "bad boy" his teacher would have regarded him as "incorrigible" and a social worker might have called him "socially maladjusted". At the same time the psychologist might have referred to him as "emotionally disturbed".

Traditionally, emotional disturbance has been regarded in terms of labels denoting types of psychopathology. This procedure although useful in communication between certain homogeneous groups of diagnosticians has been of limited use to the educator and child care workers who are more concerned with effect than cause.

Attempts to determine the incidence of emotional disturbance according to Barlow (1966) have been greatly complicated by the lack of a commonly accepted definition. As a result incidence figures vary according to the definition and identification criteria employed. Glavin and Quay suggested in 1969 that greater significance should be attached to patterns of maladjustment than to incidence of emotional disturbance.

Earlier findings which suggested that twice as many boys as girls were identified as emotionally disturbed were supported by McCaffrey and Cumming's 1967 study. Their findings indicated that 78% of the boys and 66% of the girls identified as being emotionally disturbed also had learning problems. This study strongly suggested that in many cases observed behavior problems may be secondary to other basic problems.

Early History

Tracing historical accounts of emotional disorders of children has amazingly enough indicated an absence of such literary mention before the eighteenth century. Folklore which has seized upon every conceivable aspect of human life has been peculiarly silent. The biological, medical and fictional writings had nothing to say. This does not warrant the assumption that infantile emotions always ran a smooth course in the past and that the occurrence of their disturbances is a relatively recent phenomenon. The truth is that, aside from occasional pious pleas for nondescriptive philanthropy, our ancestral lawyers, physicians and philosophers seem to have been indifferent toward the afflicted among many categories of the young and, for that matter, of the grown-ups as well. It was not until the decades immediately before and after the French and American revolutions that the new doctrine of the rights of the individual engendered an unprecendented spirit of humanitarian reforms. For the first time handicapped children were seen and heard.

A seven year old offspring of an aristocratic family, whose father remarried after an unhappy first matrimony who offended her

'noble and godfearing' stepmother by peculiar behavior was described in the masterful autobiographical novel Sir Grune Heinrich by Gottfried Keller (1921) in whose native village the incident had taken place in 1713.

Esquirol (1838) reported on the cases of three "little homicidal monomaniacs". Descuret (1841) told of a boy taken away from a nurse who had lived with him for his first two years, who grew pale, sad and morose, refused to eat, and did not respond to his parents. This literary account indicated the first emerging desire to look for possible explanations of deviant child behavior on other than pseudo theologic and pseudomoralistic grounds.

Mardsley (1867) included in his Physiology and Pathology of Mind a chapter on "Insanity of Early Life". In it he tried to correlate symptomatology with the development states at the time of onset and suggested classification of infantile psychoses.

In the last two decades of the nineteenth century, attempts were made to collect and organize existing material in monographs of "psychic disorders", "mental diseases" or "insanity of children". There were texts by Ebbinghaus (1887) in Germany, Moreau de Tours (1888) in France and Manheimer (1899) in Ireland. There was a tendency toward fatalism which saw disorders as the irreversible results of heredity, degeneracy, masturbation, overwork, religious preoccupation, intestinal parasites or sudden change of temperature.

In 1900 Ellen Key, the famous Swedish sociologist, made her much-quoted prophetic announcement that the twentieth century was destined to be "the century of the child". About that time the diaries

of Preyer, Darwin, Pestalozzi, Tiedmann and other writers expanded by Stanley Halls questionnaire had paved the way for the new science of developmental psychology and the monumental work of Binet, whose first draft of the psychometric scale was made public in 1905. This was the year in which Freud on the basis of elicited adult patient's reminiscences had given literary form to his theory of infantile sexuality. Three years later, Clifford Beers introduced the idea of the prevention of mental illness, focusing on the need to intercept behavioral deviations at the time of their earliest appearance.

Yet it was not until the 1930's that consistent attempts were made to study children with severe emotional disturbances from the point of view of diagnosis, etiology, therapy and prognosis. The change occurred with the realization that children were not immune to the illness Kraepelin described as dementia praecox and referred to by Bleuler as the group of schizophrenias. Dr. Sanctis (1925) had suggested the "dementia praecocissima" for an assortment of marked disturbances appearing in preschool age. Ssucharew (1932) in Russia, Lutz (1937) in Switzerland and Despent (1938) began to search for clear demarcation of existing variations in onset, symptoms and course.

In the 1940's a period of controversy and confusion was inaugurated because of the parallel advocacy of two antithetical trends. On the one hand, there was a tendency to pre-Kraeplinian indefiniteness. Beata Rank (1949) introduced the notion of the "atypical child" with intended disregard of any distinctions between childhood psychoses, mental defect and any other form of "severe disturbances of early development". Problems of mother-child relationships were declared

to be a common causative denominator. Szurek proclaimed categorically:

> we are beginning to consider it clinically fruitless, and even unnecessary to draw any sharp dividing lines between a condition that one could consider psychoneurotic and another that one could call psychosis, autism, atypical development or schizophrenia. (Szurek, 1956, p. 513)

On the other hand there was a decided disinclination to house an assortment of heterogeneous clinical entities under one supposedly common etiologic roof. Kanner (1943) outlined the syndrome of early infantile autism. Mahler (1949) described a form which she named symbiotic infantile psychosis. In the same year Bergman and Escalona called attention to what they called children with unusual sensitivity to sensory stimulation. Bender (1954) seeing the origin of childhood schizophrenia in a maturational lag at the embryonic level, subdivided the condition in three clinical types: the pseudo defective or autistic type; the pseudo neurotic or phobic obsessive compulsive, hypochondriac type; the pseudo psychopathic or paranoid, acting out, aggressive, antisocial type.

It is indeed strange that seek as one may it is impossible to find anywhere a definition of the term "emotionally disturbed child" which has been used widely. It seems to be used at times as a generality with no terminologic boundaries and at other times with reference to certain psychotic and near psychotic conditions. This point is important and seems to be a major limitation of past, present and planned research in this field.

## The Therapeutic Milieu

Despite the controversy surrounding the definition of emotional disturbance the need for treatment of emotionally disturbed children became apparent. Following many unfortunate initial treatment philosophies based on group custodial care of children, perceiving the needs of institutional populations as habit training, vocational education and wholesome outdoor living, a concept of therapeutic environment began to gain acceptance. In addition, people began to see the ultimate goal of institutional treatment as being to return the child to his community with the ability to cope with problems and live in comparative peace with himself and others. Involved in this approach was the creation of a therapeutic environment for each child in which the total life was planned toward resolution of conflicts, the development of ego strengths and the adoption of standards of behavior. Regardless of the broad diagnostic category of disturbance — schizophrenic, neurotic, or severe character disorder, the need for a therapeutic or helping experience that combined treatment by the environment with individual, clinical and remedial services was accepted as a common approach to the problem of returning the child to the community.

## Definition of Therapeutic Environment

To define a therapeutic milieu is a somewhat complex task because of the variation of resources, physical and geographical settings available to different agencies. There are, however, fundamental principles and characteristics that were found to guide the development of the therapeutic milieu in any setting.

Phelan (1962) stated that since treatment of disturbance in children was accepted as a clinical undertaking one must continually assess the child in terms of his health, his pathology, his abilities and liabilities, and his life patterns and experiences in order to understand him and how he became that way. He further stated ...

> one must understand that he is not only a disturbed child but that he is a child and has needs of a child -- biological, spiritual, educational, social and psychological. He must be nurtured by loving adults who understand him. (Phelan, 1962, p. 2).

What was distinctive was the manner in which the ingredients of life were designed, the pacing and the doseage of life experiences. As in all extra mural treatment, human relationships were seen as providing the key to basic learning.

In his book, The Therapeutic Community, Maxwell Jones viewed treatment per se as existing in normal interactions and life experiences of healthy, community life. Phelan (1962) indicated that children separated from their communities and families need an institutional environment that was focused as much as possible on the "reality" world of living with a greater number of prescribed relationships with people than the child might have in his own community. This framework of interpersonal relationships with staff therefore became a setting with a well-defined therapeutic goal for the individual child. Phelan stated:

> the environment necessary for treatment must, therefore be benign and accepting, one in which moral standards are high, one that communicates a feeling of security to the child that results in self-expression and learning as well as insight concerning

interpersonal problems. (Phelan, 1962, p. 3).

Dubois (1967) described the essentials of a residential treatment program for emotionally disturbed as involving:

a) firm external controls

b) provision for an on campus school specifically tailored to the needs of each child

c) exposure of the children to mature consistent and responsible adults who could provide a warm yet firm relationship with the child (Dubois, 1967, p. 30).

Lassiter (1966) identified the following goals in the care of emotionally disturbed children:

a) a relationship based on trust

b) safe limits on impulsiveness and aggression

c) a respect for the child's needs for individuality and autonomy.

In considering elements of a therapeutic environment one must look at the child and the environment and how they act upon each. The fundamental purpose of a therapeutic environment was seen as being the impact of a planned or prescribed program of living within the institution that would help the child return to the community.

Redl and Wineman (1952) outlined the importance of such elements as physical equipment, rules and regulations, policies for governing behavior of staff and children, the strategy of selected life situations from all resources in the agency, and the implementation of these decisions.

Also to be considered according to research in this area were

the basic attitudes of the staff toward the child and the skill and technique required to work in such an institution. Although it was generally recognized that certain innate personality characteristics were helpful, a great deal of effectiveness was seen as depending on the setting of the agency and the creativity imagination and motivation of the staff to carry out the treatment program. Among other important elements outlined were the day to day program of structured activities including school, recreation, child care practices around meals and bedtime, the association of children and adults and the activities of children with one another. An orderly environment was seen as tending to lessen the child's fears and anxieties and encourage potentialities for growth and adjustment.

In addition to the clinical assessment of the population the organizational structure of the institution was seen as an important element in such an environment. Plelan (1962) stated:

> the duties of all participating disciplines with the institution must be clearly defined and coordinated in addition to being flexible to the needs of the individual child. This requires a administrative sensitivity at all time to the population being served and to the resources of the staff. (Phelan, 1962, p. 4).

The opportunity for free communication and integration among these various members of the team was seen as essential to the child's total experience and provided the rationale for frequent meetings, conferences and other forms of informal integration of staff.

Therapeutic value was also seen in a relationship between a carefully screened and supervised volunteer and the disturbed or

delinquent child. Communication, verbal and non-verbal, of an interested and participating community was seen as helpful in lessening the feelings of rejection that children in institutions commonly feel. Volunteers have contributed greatly in creating a reality environment for children in such settings and have decreased the isolation and sterility of institutional living.

Another feature outlined by early research was the need for assignment of staff and the formulation of groups of children and adults such that interactions were tension minimizing. Implicit in this reduction of tension was the understanding and objective of re-directing aggressive and/or destructure activity into socially.acceptable and constructive activities in addition to fostering transactions which are mutually need satisfying. Matsushima (1962) on his research on the residential treatment of emotionally disturbed children stressed the importance of group work describing residential treatment as affording an ideal laboratory for the investigation of group concerns. He stated group work knowledge must be an integration of a multiplicity of processes with its major tools including informal social activities as well as verbal communication. The group workers responsibilities were viewed by Matsushima as including:

a) the institition as a whole

b) development of purposeful recreation program

c) direct leadership in treatment groups.

Behavior Modification

Essential for the effective residential treatment of emotionally

disturbed child is the ability of the milieu to change or modify behavior.

In the 1700's Rousseau wrote an hypothetical account of rearing a child, Emile, in which he proposed procedures to prevent or to eliminate problems he felt were caused by adult's social interaction with children. In dealing with crying, he advocated withholding adult attention for crying and instead attending to the child when he did not cry -- a procedure markedly similar to that used by Hart, Allen, Buell, Harris and Wolf (1964) to eliminate inappropriate crying of children. Rousseau's hypothetical account of child-rearing procedures and the environmentalist philosophy of Loche and Cordillac influenced Jean Marc-Gasport Hard (1962) in his attempts to civilize the Wild Boy of Aveyron from 1801 to 1806. Itard's attempts to remediate the behavior problems of the wild boy included procedures for training nonverbal and limited verbal imitation, for matching physical objects and for drawing and writing which were markedly similar to those used by Lovaas and his colleagues in 1966 and 1967 with schizophrenic children. Sequin, a student of Itard, further developed and formalized Itard's procedures and established schools for the education of retarded children in England, France and the United States.

After Sequin, however, the only portions of these therapeutic procedures which seemed to persist until present day were preschool programs which were heavily influenced by Maria Montessori, a student of Sequin.

The social learning approaches assumed that deviant and adaptive behaviors were acquired during the process of interacting with people. It also assumed that one of the main components involved in the teaching process were the consequences applied by one person for the behavior of the other person.

Patterson (1969) made the assumption that many deviant child behaviors are acquired and maintained as a function of positive social reinforcers supplied by the peer group, teachers and the family. There were a number of studies which provided observational data showing that reinforcing contingencies were provided by peer groups for a wide variety of deviant child behaviors including aggression (Patterson, Littman and Bricker, 1967), delinquency (Buehler, Patterson and Furness, 1966) and disruptive classroom behaviors (Ebner, 1967). The data collected showed that even mothers provided reinforcers for deviant behavior (Hawkins, Peterson, Schweid, Bijou, 1966; Wahler, 1968; Patterson, Ray and Shaw, 1968). The hypotheses and preliminary supporting data agreed in underlining the fact that the social environment is quite "irrational" in its support of deviant behavior.

These preliminary findings suggested that the generalization and persistence of intervention were less a matter of stimulus generalization (mediated or otherwise) and more a function of reinforcement control. While generalization of effects necessarily varied as a function of similarities in the stimulus properties of the setting it was felt unlikely that such stimulus control was of much importance beyond the first few responses emitted by the child. Thus according to Patterson

(1969) the focus of intervention was seen as being the alteration of the social system within which the child responds. In such an approach it was seen as becoming necessary to program not only the changes in the reinforcing contingencies supplied by the dispenser, but also to provide the reinforcers necessary to maintain the behavior of the dispenser.

Some Related Research on Treatment Programs

Although a number of studies have been done at various institutions, Matsushima (1965) has pointed out the difficulty in conducting such research and the meaninglessness of many of the findings.

> No single criterion or a mechanical totalling of several criteria appears to reflect the interaction of intrapsychic and environmental influences associated with successful treatment. (Matsushima, 1965, p. 6)

Minimally Matsushima (1965) favored the concept of adaptation, in which a child's observable ability to find satisfaction in a harmony with reality was primary. Embodied in this concept were the features, therefore, of observable improvement in functioning as well as improved intrapsychic adjustment. Siatuational determinants were seen as prominant determinants of treatment outcome and Matsushima(1965) stressed the quality of family involvement and institution of social factors.

Goldsmith (1963), in his article on treatment milieu based on a study at Cedar Knolls School in Hawthorne, New York stated mental healing to be the result of interaction and residential treatment programs for children as involing hour by hour management in all phases of living. The milieu was seen as constituting the attitudes of personnel around the child forming a psychological atmosphere.

Lerman (1968) pointed out the tendency of institutional research to demonstrate success on the basis of reinstitutionalization rather than realistic means.

Cowden (1966) rated neurotic and socially delinquent groups of 45 and 63 boys, respectively, after a two year period. No significant differences were found between the groups for institutional adjustment but the neurotic delinquent should significantly more positive post-release adjustments.

In 1964 Reiner demonstrated the capacity for social adaptability that adolescents possess when normally close relationships with parental surrogates are provided.

In his study of personality patterns of pupils in special classes for emotionally disturbed, Quay (1966) had teachers rate children on a check list of problem behaviors. Factor analysis of the intercorrelations of the behaviors indicated that three factors could account for 76 percent of the variance. These were labelled conduct problems or unsocialized aggression, inadequacy or immaturity and personality problems or neuroticism. Results were consonant with similar studies that suggested different programs for emotionally disturbed children be available depending upon the primary behavioral characteristics.

R.W. Persons in his research at the Airfield Conneticut School for Boys, used ability to function outside the institution as his criterion for progress and found treated boys showed more improvement on a variety of psychological test measures after forty sessions of group therapy and twenty sessions of individual therapy than did a control group who had no treatment. A follow up check done ten months

after each boys release found fewer back in institutions and more employment among treated boys than among those not treated.

In a follow up study of 50 poorly adapting boys at Bellefaire, Allerhand, Weber and Haug (1966) found:

a) There was relatively high success, both within Bellefaire and at follow up, despite the severity of disorder within an institutionalized population.

b) Positive adaptation to the institution did not forecast adequacy in the post-Bellefaire environemnt (Children adequate at discharge were not necessarily adequate at follow up).

c) The nature of situational factors, particularly after discharge was significant.

d) Implementation of the aftercare plans suggested by the Bellefaire staff was important.

e) The child who actively participated in the community (school and/or work) was most likely to make an adequate post-institutional adaptation.

f) Length of stay was not significantly related to adequacy of post-institutional adaptation.

g) Reports made by the child about his therapy experience were significantly accurate.
(Allerhand, Weber, Haug, 1966, p. 152).

A study done by Neiman and Woolley (1971) assessing treatment results in six residential treatment centres in Manitoba indicated three areas in which a large proportion of the children were functioning below a minimal level of adequacy.

a) School

b) Relationships with peers.

c) Adjustment to family living.

Related Research on School Programs

Essential to any residential treatment concept for emotionally disturbed children is a school program geared to the needs of the individual child.

Faar (1970) outlined basic principles essential to educational approaches with emotionally disturbed children. Fundamental here was the premise that the emotionally disturbed child could learn which called for an extinction of old school patterns. Faar called for a setting which demonstrated new patterns and reinforced the new learning by showing schools to be a place where gratification and predictable environments can exist and where help is available.

Atcheson and Alderton (1964) pointed out the need for an agency dealing with psychiatrically disturbed children to maintain liason with community schools so as to permit placement in community schools once a child is ready.

Hay and Cohen (1967) in their disucssion of perspectives for a classroom for disturbed children suggested that to seek adherence to accepted norms of behavior was to confuse goals with current readiness. It showed a lack of consideration of the controls of deviant behavior - the gap in development, constricted experiences, self-defeating defense mechanisms, conflicts, anxieties, physical and family trauma which resulted in failure to help large numbers of children.

Hollister and Goldston (1962) outlined a beginning effort at a taxonomy of methods used in special classes for the emotionally disturbed and pointed to methods of motivational live and perceptual retraining along with processes of diagnosing and reinforcing ego strengths and using group development methods as trends for the future.

Hewett (1967) described the engineered classroom with a purposeful, controlled and productive atmosphere. Basic to this concept was the behavior modification model requiring the use of a teacher aide and tangible rewards. Observation suggested that the value of checkmarks and tangible exchange soon gave way to the satisfaction of succeeding in school, receiving recognition as a student from peers, teachers and parents.

The Elgin special class for emotionally disturbed children was opened in 1964 with three objectives:

a) Reconditioning of deviate nonintegrative classroom behavior.

b) Attainment of academic achievement commensurate with abilities.

c) Eventual return to the regular classroom with adequate behavioral and academic functioning. To achieve these goals children were admitted at an age amenable to reconditioning (age 6-10 years), parents became involved in therapy, an effective plan for educational diagnosis was devised and individual programs of remediation were developed on the basis of diagnostic findings. The following diagnostic outline was devised:

i) determination of capacity for learning using intelligence testing and personality evaluation.

ii) evaluation of achievement.

iii) determination of discrepancy between achievement and capacity.

iv) analysis of diagnosis which included an evaluation of perceptual abilities believed to be directly related to classroom achievement and areas of difficulty exposed by psychological and educational testing.

v) plan for remediation, which was directly related to diagnosis and considered one problem at a time.

An evaluation of the program nine months after its conception revealed that the class was achieving its goals. New and more flexible patterns of behavior had been learned, enabling integrative adjustment to precipitating situations. Academic progress was three times as great as prior to special class assignment with five of seven students originally admitted having returned to regular classes.

Bloom (1966) in his discussion of psycoeducational aspects of classroom management outlined rational for effective program procedures for the emotionally disturbed:

a) reducing the level of anxiety which leads to disorganized behavior.

b) cutting down on stimuli action in the classroom by using a shield board.

c) allowing a phobic child who becomes anxious when new learning material is introduced to return momentarily to familiar material then move ahead.

d) providing appropriate age reading interests.

e) responding to correct and wrong answeres in a neutral way since correct and wrong has

strong connotations of good-bad and love-reject.

f) helping a child accept "I don't know" and failure as a part of learning.

g) using academic regression introduced by the teacher to further strengthen basic skills in such a manner that self-esteeme is not injured.

h) substituting competition with oneself for intense competition with others. (Bloom, 1966, p. 383).

In their paper presented at the annual meeting of the American Orthopsychiatric Association Fieldand Herbig (1970) generated a number of assumptions regarding the inter-relationships of education and therapy:

a) The learning alliance and process and the therapeutic alliance and process are essentially congruent reciprocal developments. The teacher and therapist carrying out their functions in a complimentary manner based on shared, accurate diagnostic understanding of the child can effect substantial and permanent alterations in the child's learning disability.

b) The classroom was seen as a place to implement change with the group interaction system affording the teacher an unique diagnostic opportunity as well as leverage for the therapeutic intervention.

c) The therapeutic progress and its outcome may be decisively affected for the good or ill by the vicissitudes of the teacher-child interaction.

d) The classroom experience, while it activates many of the same

kinds of conflicts that arise in therapy puts its emphasis on the side of "adaptive ego". The teacher must understand and utilize conflict and anxiety in the services of the learning task even though his focus unlike a therapist is on the task rather than the underlying conflict. Field and Herbig concluded that through the functions of an ongoing process between therapist and teacher a school could provide:

i) an extended diagnostic field of observation which has important implications for treatment planning.

ii) an action laboratory to study, test out and formulate new approaches as dictated by the ever changing developments in therapy and in school.

iii) increased therapeutic impact through unified and simultaneous intervention of teachers and therapists.

iv) an opportunity to develop a new breed of "clinical educator".

Admissions to Institutional Treatment in Alberta

D.D. French (1969) tabulated admission statistics during the period November 1968 to October 31, 1969 which were stated by the Child Welfare Admissions Committee as indicative of the number of expected applications to be dealt within a given year.

During this period the Child Welfare Admissions Committee considered a total of 341 applications. Thirty-four percent of the total applications came from agencies in the City of Calgary; 46 percent from agencies in the City of Edmonton.

Breakdown by Age and Sex

Of the total applications 57% were for male children and 43% for female children.

Of the processed applications 87% were for children over the age of ten years and 67% were for children between the ages of thirteen and seventeen years while 60% of the applications processed were for children between the ages thirteen and sixteen years.

In the age group under thirteen years of age, only 23% of the applications were for females but in the age group over thirteen years of age, the percentage of females increased to 52%.

Table 1

Status of Children Admitted to Institutional Treatment in Alberta

| Status | Male | Female | Total | % of Total |
|---|---|---|---|---|
| Temporary Ward | 65 | 63 | 128 | 37.5 |
| Permanent Ward | 48 | 19 | 67 | 19.9 |
| Non-Ward-Care | 12 | 12 | 24 | 7.0 |
| Social Allowance | 9 | 4 | 13 | 3.9 |
| No Welfare Status | 25 | 20 | 45 | 13.2 |
| Under Apprehension | 35 | 29 | 64 | 18.5 |
| Totals | 194 | 147 | 341 | 100.0 |

Shortly after this report, departmental policy was amended in

that all children placed in child care institutions had to come under one of the child care programs (temporary or permanent wardship or non-ward care).

Table 2

Marital Status of Parents of Children Admitted to Institutional Treatment in Alberta

| Marital Status | Number |
|---|---|
| Married and living together | 80 |
| Married and living apart | 110 |
| Legally separated | 3 |
| Divorced | 63 |
| Living common-law | 15 |
| Common-law but living apart | 40 |
| Child of unmarried mother (surrendered) | 21 |
| One parent deceased | 5 |
| Both parents deceased | 4 |
| Total Cases considered | 341 |

Of cases considered, 72% came from "broken homes" (parents married but living apart, legally separated, divorced or common law living apart).

Table 3

Racial Origin of Children Admitted to Institutional Treatment in Alberta

| Father | Mother | Total | % of Total |
|---|---|---|---|
| White | White | 209 | 61.4 |
| Metis | Metis | 51 | 14.6 |
| Indian | Indian | 21 | 6.2 |
| Negro | Negro | 1 | 0.2 |
| White | Indian | 10 | 2.9 |
| White | Metis | 21 | 6.3 |
| Metis | White | 9 | 2.8 |
| Metis | Indian | 10 | 2.9 |
| Indian | White | 4 | 1.4 |
| Indian | Metis | 2 | 0.7 |
| Negro | White | 1 | 0.2 |
| Negro | Indian | 1 | 0.2 |
| Oriental | White | 1 | 0.2 |
| Totals | | 341 | 100.0 |

Thirty-seven percent (128/341) of the children considered came from families of Indian or Metis extraction. This figure was seen as significant when one considers that native people comprise a small percentage of the general population.

During this period the Westfield Diagnostic and Treatment Centre admitted eighty-five males which was 43.9% of the total male applications approved and fifteen females which was 10.2% of the total female applications approved.

Committee Recommendations

On the basis of their research the committee recommended that the Child Welfare Branch give priority to:

a) increasing the competence of regional social workers and supervisors to make sounder assessments.

b) including family counselling as a major function and responsibility of field staff involved in carrying out the child welfare programs.

c) strengthening the roles of receiving centres and detention centres from custodial services to that of observation, assessment and recommendations regarding placement.

d) insuring sibling contact in cases of apprehension.

e) improving discharge planning and follow up services for children in institutions.

f) training workers to enable them to give foster parents specific and intensified support in their workings with wards.

g) investigating the possibility of creating special foster

homes in which parents are better equipped to deal with emotionally disturbed children.

h) surveying caseloads to determine the extent of the problem of placement of older teenage wards.

i) conducting a survey of children presently under care to determine the extent of problem children who are below average ability.

Summary

Considering research findings in the area of emotional disturbance a common theme has pointed to procedures for identifying, understanding, and working with children affected by emotional disability.

Described as essential to the residential treatment of emotionally disturbed children is the creation of a therapeutic environment which will co-ordinate interdisciplinary therapeutic involvement so as to meet the individual growth needs of the children who live there. Planned relationships and experiences of interaction between adults and children along with the establishment of a healthy reality world were seen as forming the basis for a therapeutic environment which would enable functional use of remedial and clinical services.

## Chapter III

## Westfield Edmonton Diagnostic and Treatment Centre

### History

On August 1, 1964, a pilot project to study and put into practice proposed concepts for a Diagnostic and Treatment Centre for emotionally disturbed children became operational at the Edmonton South Side Boys' Home. The South Side Boys' Home had become available as a temporary resource and testing ground because the city had moved all boys being held on juvenile charges to their new Detention Centre.

Although feedback from this pilot project resulted in a green light for construction of an Edmonton Diagnostic and Treatment Centre, delays involving completion of plans and construction problems held back opening until July 24, 1967. Basic to this philosophy of treatment was the concept of therapeutic environment or milieu treatment for emotionally disturbed children. Initially the Centre was operated through the Homes and Institutions Branch of the Department of Health and Social Development. Later, the responsibility of the operation of the Centre was changed to the Child Welfare Branch. Presently, the Centre answers administratively to the Homes and Institutions Branch and consults with the Child Welfare Branch as far as the treatment aspects of the program are concerned.

### Setting

The complex is not isolated from the community but, located within the City of Edmonton in Alberta. It is of modern architecture so as not to stand in stark contrast to surrounding homes and consists of three treatment units, three smaller cottages, an administration building with an adjoining school, a recreation building and group homes.

The grounds are landscaped to include small playgrounds, a skating rink, a sports field, a covered walkway extending between units and several small patios.

Planned architecture in the units follows a ranch style decor with high beam celings, a large kitchen, dining and living area with an open fireplace, a craftroom, a small gym, a workshop, sewing and laundry rooms, staff rooms, an office, a piano room and two dorms - one for males and the other for females. There are mainly single rooms with the shared rooms containing no more than three persons. Cottages are constructed along the same style, although smaller and perhaps more like other homes in the community.

Seven group homes - five for boys and two for girls, are located in the community but staffed and administered through the Centre.

Status of Child

All children who are admitted to the Centre are the responsibility of the Director of Child Welfare of the Department of Health and Social Development, and are categorized in one of the following classifications:

a) Permanent wards - includes all children whose parents or guardians have relinquished all their rights to the welfare of that child and the courts decide this step to be in the best interest of the child.

b) Temporary wards - includes children who have appeared before a Juvenile Court where a decision for wardship has been made on grounds of parental neglect or lack of control or delinquent behavior by the child in the home, community or school. In the case of temporary wardship, the parents retain involvement but have no jurisdiction over the child. The child can be a temporary ward for three years.

c) Non-ward care - includes children whose parents have requested the Director of Child Welfare to accept responsibility due to their inability to cope with their child's behavior at home, school or in the community.

All children classified as permanent or temporary wards must be classified as such through a court order, whereas children on non-ward care are classified through the signing of an agreement between the parents and Director of Child Welfare.

All referrals to the Westfield Diagnostic and Treatment Centre must be initiated through any of the regional offices of the Department of Health and Social Development and involve completion of a case study application which is then forwarded by the Admissions Committee. Applicants forwarded by the Admissions Committee are interviewed along with their family by the intake social worker at the Centre who, along with the Director, unit or cottage social worker and school principal, form the Centre's Admission Committee.

The Units, Cottages and Group Homes

At Westfield Diagnostic and Treatment Centre the unit or cottage is the living unit for the child. There are two open units which house approximately twenty children and one closed with locked doors for children who need a more structured setting becaue of their inability to maintain themselves in the less structured settings throughout the rest of the complex or because of their history prior to admission. This unit houses approximately twelve children. Ages of children in units usually range from about 12 to 16 or 17 years.

The cottages offer less institutional programming, and structure

and cater to the younger children or those ready to cope with more responsibility but perhaps not quite ready for a community setting. There are three cottages which house approximately ten children. from as young as 2 or 3 years (although admissions this young are rare) to 14 or 15 years.

The group homes are designed to meet a variety of needs:

a) They are a resource for permanent wards who have been through a series of foster homes which have failed, and find group homes less threatening since they can first relate to the peer group in the home.

b) They are a resource for temporary wards or non-wards in cases where the child may still be having some interpersonal relationship problems that need to be worked out before they are able to return to their parents.

c) They are a resource for children who are still in need of a great amount of emotional support while they are making the adjustment to community and family living from a more structured institutional setting.

Their schooling and recreational activity is all community based with a social worker from the Diagnostic & Treatment Centre maintaining contact with the schools and the community resources as well as acting as a liaisonwith the social workers at the regional office.

Staff Structure and Responsibilities

The staff at the Centre consists of a director, social workers, a recreation director, child therapy counsellors, a nurse, houseparents, institutional service workers, cooks, a supply clerk and

stenographic and clerical office staff. Consultants consist of a psychiatrist, psychologists, a pediatrician-neurologist, and endocrinologist, an opthamologist and several dentists. There are also staff members from the Department of Public Works employed at the Centre for caretaking, maintenance, carpentry and gardening.

Each unit or cottage is headed by a social worker whose responsibilities include:

a) contact with regional office social workers as well as others involved with the child and his family.

b) supervision of the Child Therapy Counsellor II employees and indirectly all employees in the unit or cottage.

c) general administration of the unit or cottage as outlined by the director.

d) liaison with other members of the treatment team, psychiatrist, psychologist, school officials, physician, nurse and child therapy counsellors. The social worker attends all case conferences involving children under his supervision and reports on social history, individual and group casework and family therapy.

e) coordination of up to date records of all children in the unit or cottage and submission of regular progress reports to people concerned.

f) staff placement and assessment in the unit or cottage.

g) organization and co-ordination of regular staff meetings and participation in in-service staff development programs.

h) initiation and maintenance of contact with families of

children in the unit or cottage, instituting family therapy wherever indicated.

i) facilitation of community contacts for the child.

j) group therapy and facilitation of therapeutic encounter of staff and children.

One of the social workers serves as a co-ordinator and consultant for intake, volunteer programs, and family therapy.

Working with the social worker in the units are treatment teams headed by a Child Therapy Counsellor II employee. The team approach with the units was not part of the original philosophy of the Centre however, was experimented with in 1968 and adopted in 1970. Advantages of a therapy team approach within the unit were felt to included increased consistency with the children as well as increased staff co-ordination and balance.

Responsibilities of a Child Therapy Counsellor II employee includes:

a) supervision of a staff of Child Therapy I workers on a shift basis.

b) maintenance and development of an environment necessary for therapeutic programming.

c) observation and recording of the day to day experiences of each child which are pertinent to the child's development.

d) attendance at case conferences and co-ordination of residential reports relevant to the case under discussion.

e) understanding the philosophies, concepts and goals of therapy programs within the unit and importing the philosophy to

employees under his supervision.

f) evaluation of staff members and volunteers working on his team.

Responsible for carrying out the bulk of the therapeutic interaction are the Child Therapy Counsellor I employees whose responsibilities include:

a) providing and sustaining a home and family-life environment.

b) establishing and supervising a realistic home of daily routine.

c) assisting in and planning leisure time programming.

d) facilitating the establishment of good personal habits among the children.

e) meaningful participation and understanding of all facets of unit programming.

f) reporting regularly to the Child Therapy Counsellor II on progress and difficulties of each child's adjustments.

g) reporting monthly and at case conferences on group living progress of assigned cases.

Responsibilities of Housemother II's and I's in the cottages roughly parallel those of the Child Therapy counsellors in addition to including cooking and other domestic responsibilities. Houseparent responsibilities in the group homes are similar to those of foster parents.

The School

The school program at Westfield Diagnostic and Treatment Centre is operated by the Institutional Services Branch of the Edmonton Public

School Board. The school staff consists of a principal, a vice-principal and teachers. The school is of a remedial nature, individually designed to help the child overcome his learning problems as well as his classroom behavior problems. The classes are kept small usually under ten, to maximize individual lesson planning. A success orientation is stressed with little emphasis on grading or failure. Children are placed in classrooms so as not to feel out of place on the basis of age, size, or learning ability. An individual program for each student is planned an initiated through the media of scholastic ability test mechanisms.

The classrooms, architecturally, resemble the modern theme of the overall complex yet have provisions to facilitate general re-development of deviant, non-integrative classroom behavior. Most classrooms are situated in the administration-school complex, with additional rooms in each of the three units. The closed unit has its school program within the unit.

Examining basic goals of the school program involves an analysis of priorities. Of initial importance in this regard is the development of social adjustment to the school environment. In light of progress shown in adaptation to the school environment, remediation programmed on the basis of academic evaluation is embarked upon. The intention of the institutional program is to bring about sufficient change in school behavioral patterns so as to enable the child to be re-absorbed into community life. Remediation is therefore geared to "short term treatment" with movement to an outside school being encouraged as soon as the child has demonstrated he can cope adequatley with social aspects of his school setting and is sufficiently receptive to receiving

instruction. Community school placement is selected in light of resources available to meet the "long term educational needs" of the child.

Criterion for admission to the school includes residence at the Centre. Additional screening factors include severe physical or mental handicap. Children who appear to have the ability to function in a community school upon admission are encouraged to do so.

Initially classes are organized primarily on a peer compatibility basis with additional consideration given to social history and residential group living assessments. Subsequent reorganization involve learning levels and individual learning needs.

Individual student assessments constitute the basis for educational planning and are formed by pooling essentially three data inputs. Of initial consideration are past educational records which are requested as intake requirements. A second input is provided by psychometric testing data obtained by the psychologist and presented at each case conference. A third input is that of the teacher's observation and assessments. At case conferences learning capacity is compared with achievement with the resulting discrepancy providing the focus for remediation.

To attain the short term objectives of the school program at the Edmonton Diagnostic and Treatment Centre emphasis is placed on gratification and predictability. Some of the principles incorporated within this philosophy include:

a) individual teacher contact

b) reduction of confusing classroom stimulation

c) establishment of realistic working levels in various subjects.

d) simple progression in learning.

e) avoidance of excessive frustration and anxiety..

f) consistency.

g) structured and directed activities for those who need it.

h) allowance for individual differences.

i) balancing academic work with craft shop, recreational and social activities.

Modification has been employed with particular emphasis in the area of reading, where a monetary system was implemented and used for the purchase of tangible rewards.

In addition to focussing on the learning problems of each individual, the school setting provides an extended milieu in which to increase therapeutic impact and evaluate treatment objectives. Consistency of school and residential objectives are assured by case conferences every three months at which time all disciplines involved co-ordinate an overall treatment plan. Despite this additional function, however, the role of the teacher is not confused with that of a counsellor in the eyes of the children. The classroom is seen as a means of providing the child with tangible measurable evidence of his ability to achieve progress and grow.

Philosophy and Treatment

Westfield Diagnostic and Treatment Centre was established for the overall treatment of emotionally disturbed children. Children who are admitted have experienced little love or understanding of their feelings and needs from adults during most of their childhood. Although some

appear capable and healthy, these children usually feel worthless, hopeless and distrustful of themselves and adults. In contrast with other children, their time energies are not spent in learning and growing but instead in hiding their true feelings, avoiding close relationships with adults and provoking adults into rejecting them as did their parents. To provide a program for such children necessitates the creation of environment within which treatment can be functionally implemented. The personalities and behavior of emotionally disturbed children are distinct from other community children since in most cases these reflect anger and problems in dealing with their inner feelings. The underlying motivation of such behavior and treatment of the same creates a need for fundamental understanding of principles of child development and growth.

Westfield Diagnostic and Treatment Centre begins with the needs of the individual child. The combination of professional assessment data made available in case conferences and interaction of those involved in the environmental setting provide the ingredients for the establishment of a therapeutic milieu. The program at Westfield Diagnostic and Treatment Centre does not recognize the principles of change in youngsters' behaviors as resulting from any one discipline's contribution but rather the contribution of all disciplines as members of a team, continually assessing the positives and negatives of personality and character formation, and prescribing the necessary treatment direction within the therapeutic community.

Each child is case conferenced every three months, at which time assessment is made in terms of his total makeup including his

perceptions of himself, his behavior and social adaptation within the therapeutic environment and his home setting, with the ultimate objective of returning him to his home community as a responsible and productive person. Attending case conferences are the director, social worker from the Centre, the regional office social worker, the psychologist, the psychiatrist or other consultant personnel who may be involved, the teacher and principal or vice-principal from the Centre, the school psychologist and teacher if the child is attending an outside school, the child therapy counsellor and the nurse. Each member has a unique and distinct role in both assessing the sickness and health of each child's growth and in providing the necessary treatment and services to enable the youngster to overcome and/or adapt to his illness both at the Centre and in his home community.

Conferences begin with the social worker from the Centre presenting a summary of social history and assessments regarding individual, group and family therapy. He is usually followed by a regional office social worker who discusses family contact and assessment. The child therapy counsellor discusses group living and social adaptation within the unit or cottage, while the psychologist's responsibilities centre on his impressions as an outsider from interview and psychometric testing, and recommendations for therapeutic planning. The nurse provides an up-to-date medical report including an assessment in all medically related areas and the teacher reports on adaptation and learning achievement. From these various reports common themes are isolated and recommendations for therapeutic programming are tabled.

Common to each member of the residential treatment team is

their capacity and need to establish a relationship with each child under care. This quality combined with training and experience is essential in achieving the goal, which is the development of the total personality of each child. Staff members in residential treatment must be secure in their own field of professional training and must be capable of participating with members of other disciplines in the recognition that the team and environment can create growth and change in the individual child. Such an inter-disciplinary approach requires communication, coordination, interpretation, and proper assessment of the dynamic needs of the children under care at all times. Emphasis is placed on short term treatment with the return of the child to the community to live in a family setting. This placement might be the child's original family, an adoptive home, a foster home, a group home or an independent living situation.

The "therapeutic environment"(Westfield Diagnostic and Treatment Centre)is basically an accepting one and yet is designed with clearly defined expectations and consequences for behavior intended to convey a feeling of security to the child that results in self-expression and learning, as well as insight concerning interpersonal problems. Order is provided to lessen fears and anxieties so that potential for growth and adjustment can be realized. Volunteer involvement and community contact ensures an institutional environment that is focussed as much as possible on the reality world of living.

Embodied within the concept of the "therapeutic milieu" at Westfield Diagnostic and Treatment Centre is a focusing on behavior. Basic to this theory is the altering of signifi-

cant components of the social environment in which the child is interacting, for the purpose of altering or shaping deviant behavior. Using a color system regulation of privileges and rewards within the units and cottages specific behavior can be isolated and modified. The color system, ranging from red (confinement in a bedroom) to purple (unsupervised outings with extra allowance) with orange (unit confinement) and yellow (supervised outings) as transition colore, allows a focussing on specific behaviors with positive reinforcement for those which are socially adaptive and consistent consequences for those which are maladaptive. Points and star sub-systems serve to enable a further breakdown of color status in terms of specific behaviors in addition to reducing the emphasis of aversive consequences embodied in the color system. In this way emphasis on positive reinforcement for adaptive behavior can be maintained. A third function of the point or star sub-system is to link more closely behavior with consequences. The color system is designed to enable the child to gain greater control over his own environment. By pointing out the cues to which he should react and by reinforcing him for such reaction the child develops a greater repertoire of available behaviors which he can use as his color status permits more freedom and responsibility. As the child reaches green and purple, reinforcement is paired with social reinforcement similar to that which he will receive when he again enters the community.

Whereas etiology has its place in case conferences, individual, group and family therapy, emphasis in treatment within the units and cottages is placed on observable behavior. Dealing with behavior symp-

toms as well as causes is seen as important. It is often not as important to know why a child smashes his head against a wall 80 to 100 times a day as it is to stop the behavior. In many cases real causes cannot be isolated or dealt with, and for that reason, one can deal only with current behavior. The chance of new symptoms developing is diminished by the treatment of the major maladaptive behavior in that the symptom relief frees the child from limiting emotional side effects making him more open to new experiences and sources of positive reinforcement. This approach within the units and cottages provides a clear and concrete approach to behavior for house-mothers and child therapy counsellors, unclouded by the abstract concepts of many psychological theories. Within the Centre's treatment philosophy the relationship between feelings and behavior is seen as a transitive in that altering either one produce an effect upon the other.

Family Involvement and Therapy

Family contact and involvement in treatment is seen as vital in overall treatment at the Diagnostic and Treatment Centre for a number of reasons:

1) contact with the parents assures a continuous reality of parental proximity to the child.
2) contact with the parents reduces the tendency to idealize absent or rejecting parents.
3) contact with the parents reduces the tendency to shift negative feelings to surroudning parental substitutes.
4) therapy with the family reduces the tendency to repress intrafamilial conflict areas.

5) therapy with the family permits an attempt at modification of parental attitudes and handling of their children.

The family as a treatment unit is viewed as an interacting, dynamic system which is shaped by its members and in turn shapes its members. Treatment is seen as tuning in on the family system to learn how this system can distort or help the growth of the members of the family.

In cases where a child will not be going home, contact is initiated with other community placement possibilities.

Group Therapy

Group therpay or 'rap sessions' afford an opportunity to deal with the intensive pressures produced by the dynamics of residential group living. Rap session objectives include:

1) to facilitate meaningful contact and participation of group members.
2) to identify inner feelings and how they effect our behavior.
3) to learn how to give and accept feedback from others.
4) to overcome communication barriers.
5) to facilitate awareness of how we handle and integrate effective and cognitive experiences.
6) to clarify color status.

Basic to rap session philosophy at the Westfield Diagnostic and Treatment Centre is the belief that statements of understanding precede those of confrontation, advice or instruction. Statements that simply reflect, without adding flattery or faults, are encouraged. All feelings are seen as legitimate with only acts being subject to judgment and control. Feelings are to be identified and expressed whereas

acts may have to be limited and redirected. Orientations of mutual trust, joint exploration, openness and interdependence are encouraged with contact being on both verbal and non-verbal levels. Interactions are seen in terms of needs, values and feelings of participants, with feedback being:

1) descriptive rather than evaluative.
2) specific rather than general.
3) directed toward behavior which the receiver can do something about.
4) solicited rather than imposed.
5) based as closely as possible on the here and now.
6) checked to insure clear communication.

To summarize treatment philosophy at the Westfield, emphasis is put on modification of maladaptive behavior and meaningful relationships and communication.

The color system and point and star sub-systems allow a focussing on specific behaviors with positive reinforcement for those which are adaptive while, at the same time, defining clearly what is acceptable and unacceptable conduct. Purple and green colors indicate approved behavior; orange and red indicate unacceptable behavior; while yellow indicates tolerated behavior. Limits and consequences for behavior are clearly defined and firmly enforced.

Communication is based on the needs, values and feelings of participants and stresses conveyance of understanding. Help is given in a relationship of trust, joint inquiry, openness and interdependence in the hope that both the children and the residential staff will grow

as a result of their interaction.

## Chapter IV

## Study Design

### Subjects

All graduates, fourteen years of age and over as of June, 1971, of Westfield Diagnostic and Treatment Centre were used for the purposes of this study. The sample of 160 graduates was obtained from discharge records at Westfield.

Questionnaires were sent to 160 graduates of which 83 were returned. The average return of fifty to sixty percent for survey-type designs of this nature was obtained from Travers (1969) indicating that this percent of returns met minimum requirements for the purposes of this study.

### Procedure

A survey designed to measure pre-treatment, treatment and post-treatment situational variables was designed and mailed to the subjects along with form H of the Mooney Problem Check List.

Responses to questionnaries and the Mooney Problem Check List were compared non statistically with files at Westfield Diagnostic and Treatment Centre to roughly assess validity of responses.

### Treatment of Data: Null Hypotheses

Four null hypotheses were formulated for the purposes of this study:

1. There were no significant correlations between family ties during treatment and adaptation at the time of the survey.
2. Thre were no significant correlations between adaptation to the Institution during treatment and individual modifi-

ability and post-treatment adaptation indicated by the survey.

3. There were no significant correlations between institutional circumstances during treatment and adaptation at the time of the survey.
4. There were no significant correlations between situational factors following discharge and adaptation as indicated by the survey.

Adaptation Variables

Adaptation for the purposes of this study was measured in terms of residential setting, school situation, self-assessment of adjustment and problems indicated on the Mooney Problem Check List.

The residential setting variable was measured on 13 point Likert Scale with a 1 rating representing an institutional setting and a 13 rating representing living on their own successfully without assistance from the Department of Health and Social Development.

School situation was assessed by an 11 point Likert Scale with a 1 rating indicating that the subject was not attending school or working and an 11 point rating representing enrolement at a university or college level.

Self-assessment of adjustment was assessed by a 5 point Likert Scale with a rating of 1 representing strong disagreement regarding the statement "since leaving Westfield, I feel I have adjusted pretty well" and a 5 point rating for strong agreement with this statement.

Scores on each problem area of the Mooney Problem Check List were rescaled to a mean of 10 and Standard Deviation of 1.5 for

correlational purposes. Problem areas assessed included health and physical development, finances living conditions and employment, social and recreational activities, social-psychological relations, personal-psychological relations, courtship, sex and marriage, home and family, morals and religion, adjustment and school or work, the future: vocational and educational and curriculum and teaching procedure.

Family Ties During Treatment

Family ties during treatment were defined for the purposes of this study by:

a) wardship status

b) family situation prior to treatment

and c) family involvement in treatment.

Wardship status during treatment was assessed on a 3 point Likert Scale with a rating of 1 indicating permanent wardship and a rating of 3 indicating non-wardcare.

Family situation prior to treatment was assessed on a 4 point Likert Scale with a rating of 1 indicating family breakdown with all children removed and a rating of 4 indicating family intact with the exception of the subject and not experiencing serious problems.

Family involvement in treatment was measured on a 6 point Likert Scale with a rating of 1 indicating no contact and a rating of 6 indicating regular involvement in family therapy.

Adaptation to the Institution and Modifiability

This measure was defined for the purposes of this study by:

a) response to the "color system".

b) emergence of guilt feelings for wrong-doings during treatment.

c) relationships with staff during treatment.

d) opinions as to whether Westfield had helped subjects, and whether they would recommend it to a friend.

e) opinions regarding sincerity of staff.

f) opinions regarding whether school experience at Westfield was more helpful than previous school experience.

g) opinions regarding whether Westfield had helped subjects understand and deal with their problems.

Responses to the last four questions were intended to measure utilization and assimilation of treatment objectives at Westfield.

Response to the "color system" was measured on a 5 point Likert Scale with a rating of 1 indicating extreme difficulty attaining "green" or "purple" during entire treatment stay and a rating of 5 indicating attainment of "green" or "purple" quickly and during most of treatment period.

Emergence of guilt feelings was assessed by a 4 point Likert Scale with a rating of 1 indicating never experiencing guilt for misbehavior and a rating of 5 indicating experiencing of guilt for membership during most of treatment period.

Relationships with staff were measured on 5 point Likert Scale with a rating of 1 indicating no relationship with any staff or discussion about feelings or problems during treatment and a rating of 5 indicating relationships with most of the staff and discussion with them of feelings and problems.

Utilization and assimilation of treatment objectives were measured on a 5 point Likert Scale with 1 indicating strong negative

assessment and 5 indicating strong positive assessment.

Institutional Circumstances

Institutional circumstances were defined in terms of:

a) residential setting

b) school setting

c) type and extent of therapy

d) peer interaction and influence

e) community involvement

f) length of stay

Residential setting was measured on a 6 point Likert Scale with a rating of 1 indicating residence in a unit during total treatment period and a rating of 6 indicating residence in a group home during entire treatment period.

School setting was measured on a 3 point Likert Scale with a rating of 1 indicating enrolment at the Centre during entire treatment period and a rating of 3 indicating enrolment in an outside school during total treatment period.

Type of therapy exposed to was measured on a 4 point Likert Scale with a rating of 1 indicating daily programs and activities only and a rating of 4 indicating individual, group and family therapy.

Peer interaction and influence was measured on a 5 point Likert Scale with a rating of 1 indicating that peer influence got the subject into trouble and a rating of 5 indicating that peer interaction facilitated help and understanding.

Community involvement was measured on a 5 point Likert Scale with a rating of 1 indicating no community involvement and a rating

of 5 indicating community involvement at all stages of treatment.

Length of stay was measured on a 4 point Likert Scale with a rating of 1 indicating less than six months and a rating of 4 indicating 2 years or more.

Situational Factors Following Discharge

Situational factors following discharge were defined for the purposes of this study in terms of:

a) number and type of placements following discharge.

and b) difficulties experienced in the home, school and community following discharge.

Number and type of placements following discharge were measured on a 4 point Likert Scale with a rating of 1 indicating over 5 different places with a high degree of difficulty adjusting and a rating of 4 indicating only one placement since discharge with no serious problems.

Difficulties experienced in the home, school and community following discharge were measured on a 5 point Likert Scale with 1 indicating serious problems in two or more of the above areas and 5 indiating very good adjustment in all areas.

Analysis

Pearson Product - moment correlations were calculated for all variables under consideration.

## Chapter V

## Results

Four major hypotheses were constructed for the purposes of this study, correlating pre-treatment variables, treatment variables and post-treatment situations with adaptation of graduates of Westfield Diagnostic and Treatment Centre following discharge.

Adaptation was measured in terms of residential and school or work situation at the time of survey, self-assessment of adjustment at the time of survey and problems indicated on the Mooney Problem Check List.

### Residential Setting at the Time of Survey

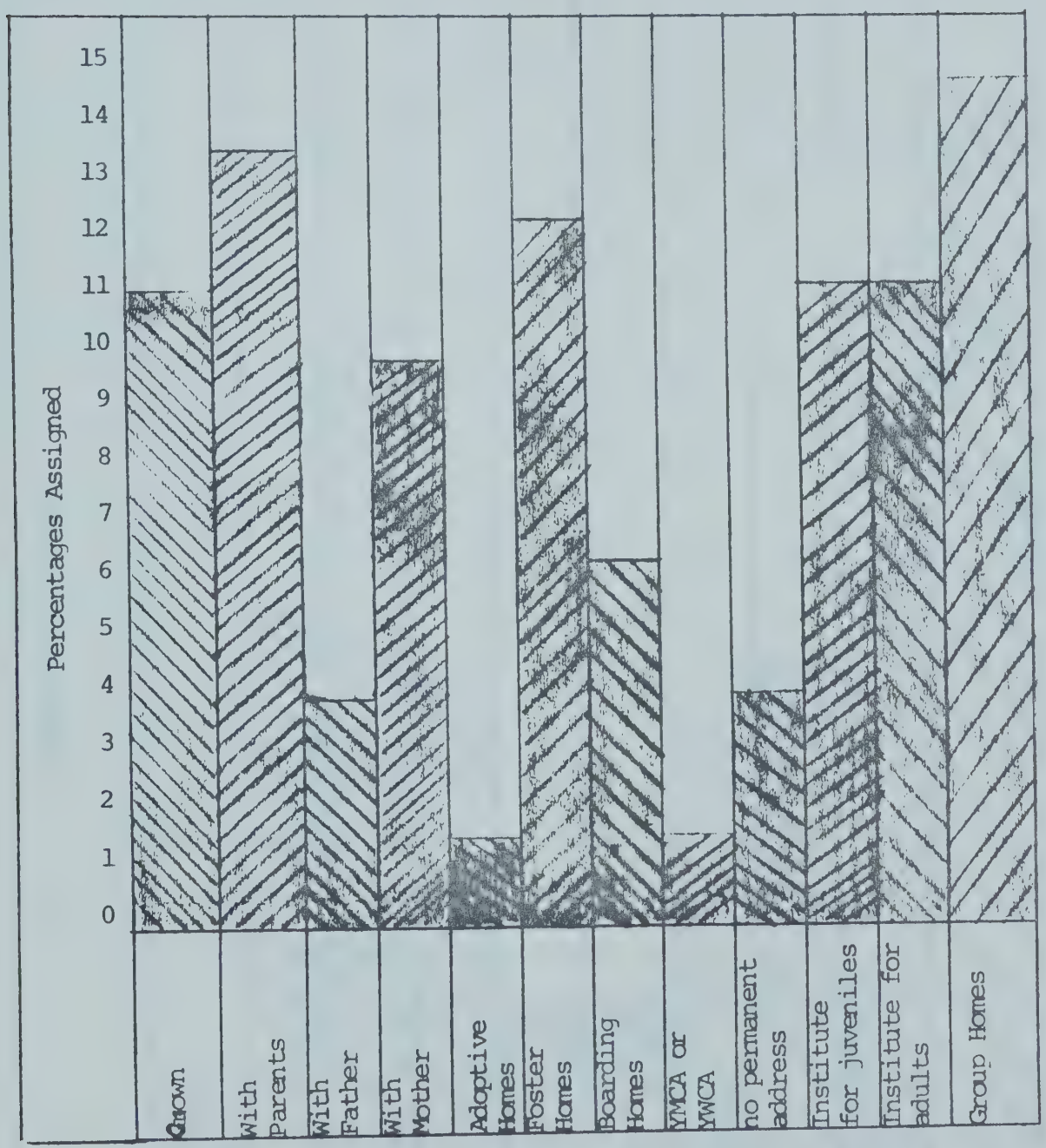
From the questionnaires returned it was found approximately 11 percent of the graduates were living on their own without assistance from the Department of Health and Social Development. It was found 13.3 percent were living with their mother and father, 3.6 percent with their father, 9.6 percent with the mother, 1.2 percent in adoptive homes, 12 percent in foster homes, 6.0 percent in boarding homes, 1.2 percent at the YMCA or YWCA, 14.5 percent in group homes, 3.6 percent were at no permanent address, 10.8 percent in institutions for adults and 2.4 percent at other residences not specified.

### School Setting at Time of Survey

Slightly more than 2 percent of graduates indicated enrolment at a college or institute of technology level at the time of survey. Approximately 11 percent were enrolled in a matriculation program at

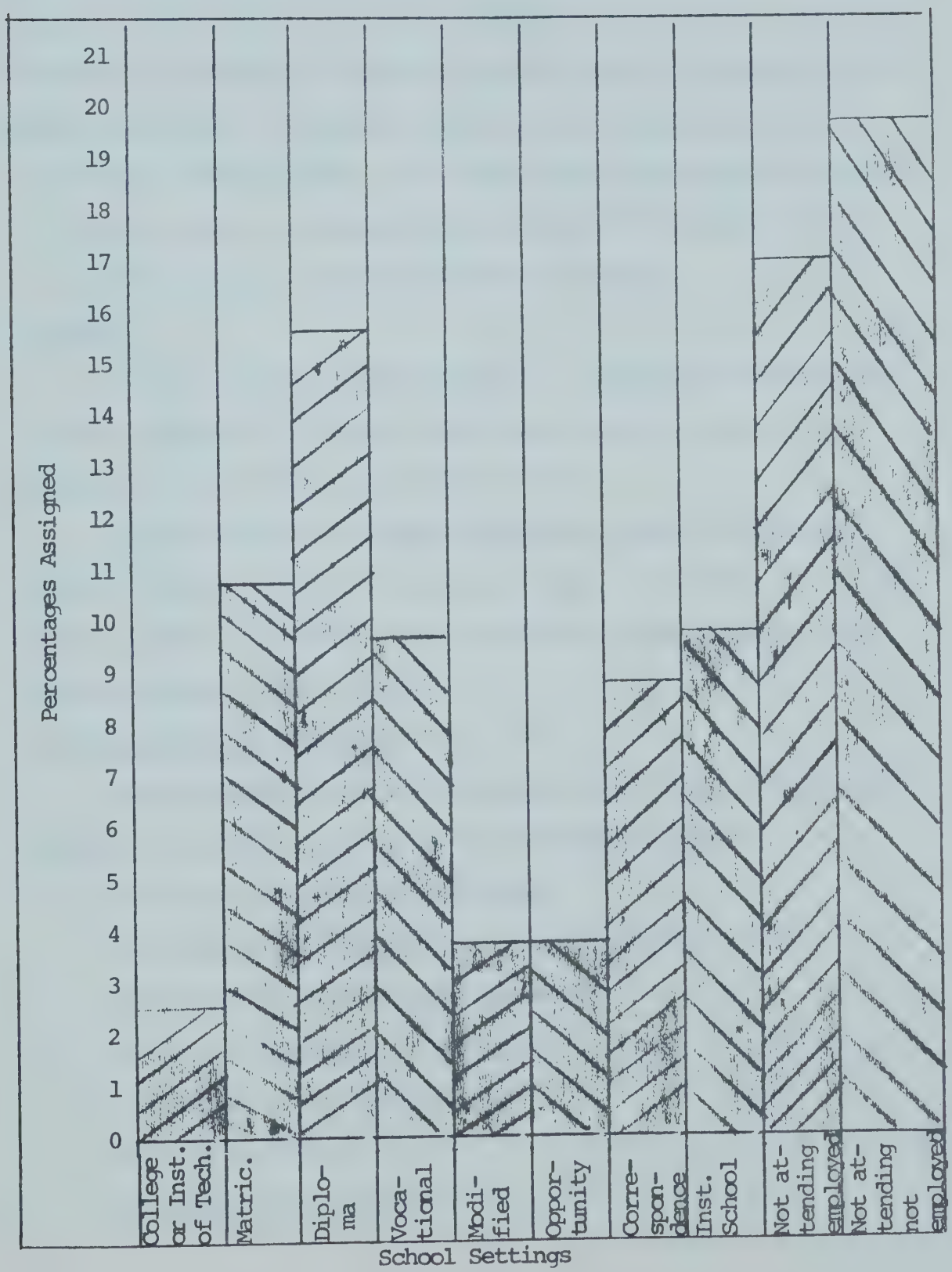
Graph 1

Percentage of Graduates in Residential Setting N=83



Graph 2

Percentage of Graduates in Various School Settings N=83



high school or junior high school, 15.7 percent in a diploma or general course at the junior or high school level, 9.6 percent in a vocational program, 3.6 percent in a modified school program, 3.6 percent in an opportunity class, 8.4 percent were taking correspondence and 9.6 percent were taking classes at an institutional school. Approximately 17 percent were not attending school because of employment while 19.3 percent were not attending school or working.

Employment

Of those working, approximately 76 percent were working when work was available, 1.2 percent less than 20 hours a week and 16.9 percent full time or 40 or more hours a week.

Approximately 82 percent were earning under 200 dollars a month, 2.4 percent 201 to 250 dollars a month, 1.2 percent 251 to 300 dollars a month 1.2 percent 351 to 400 dollars a month and 1.2 percent 600 dollars a more a month.

The Mooney Problem Check List

The High School Form of the Mooney Problem Check List assessed problems at the time of survey in the following areas:

a) health and physical development

b) finances, living conditions and employment

c) social and recreational activities

d) social-psychological relations

e) courtship, sex and marriage

f) home and family

g) morals and religion

h) adjustment to school work

i) the future: vocational and educational

j) curriculum and teaching procedure.

Hypotheses and Correlations

Hypothesis I stated: There were no significant correlations between family ties during treatment and adaptation at the time of survey.

To test this hypothesis Pearson Product-moment correlations were applied as outlined in Chapter IV comparing independent variables of:

a) wardship status at the time of treatment

b) family situation prior totreatment

and c) family involvement in treatment

with dependent variables of:

a) type of residential setting at the time of survey

b) type of school and/or work situation at the time of survey

c) self assessment of post-treatment adjustment

and d) problem areas indicated on the Mooney Problem Check List.

The correlations of family tie variables and adaptation variables are presented in Table IV.

Correlations generally substantiated the null hypothesis. There was, however, a positive correlation significant at .05 level between family involvement in treatment and post-treatment residential setting. A negative correlation significant at the .05 level was found between family situations prior to treatment and problems at the time of survey concerning adjustment to school or work.

Table 4

Pearson Product-moment Correlations of Family Tie Variables and Adaptation Variables N=83

| | Wardship Status at the time of Treatment | Family situation prior to Treatment | Family Involvement in Treatment |
|---|---|---|---|
| Residential setting | .183 | .055 | .251* |
| School situation | -.080 | -.048 | -.043 |
| Work - hours per week | .058 | -.144 | -.051 |
| Work - salary per month | .061 | -.150 | .003 |
| Self-assessment of adjustment | .125 | -.116 | .027 |
| Health and physical development | -.068 | .005 | .035 |
| Finances, living conditions and employment | -.006 | -.026 | .018 |
| Social & recreational activities | .012 | -.057 | .091 |
| Social-psychological relations | -.016 | -.012 | .097 |
| Courtship, sex & marriage | .106 | -.061 | -.016 |
| Adjustment to schoolwork | -.142 | -.243* | -.205 |
| The future vocational & educational | .094 | -.008 | .128 |
| Personal-psychological relations | .106 | -.061 | -.016 |
| Home and family | .100 | -.006 | -.042 |
| Curriculum & teaching procedure | .028 | -.159 | .025 |

*significant at the .05 level

Hypothesis II stated: There were no significant correlations of measures of adaptation to the institution and individual modifiability with adaptation at the time of survey.

To test the hypothesis, Pearson Product-moment correlations were applied as outlined in Chapter IV comparing independent variables of:

a) response to the "color system"

b) emergent feelings, particulary guilt feelings during rea treatment

c) capacity for forming relationships with staff

d) opinions as to whether Westfield had helped subjects and whether they would recommend it to a friend

e) opinions regarding sincerity of staff

f) opinions regarding whether school experience at Westfield was more helpful that previous school experience

g) opinions regarding whether Westfield had helped S's understand and deal with their problems.

with the previously stated dependent variables.

The correlations of variables measuring adaptation to the institution and individual modifiability during treatment with post-treatment adpatation are presented in Table V.

Table 5

Pearson Product-moment Correlations of Institutional Adaptation and Modifiability Variables During Treatment and Post-treatment Adaptation

N=83

| | Response to the "color system". | Emergence feeling particularly guilt feelings during treatment. | Capacity for forming relationships with staff. | Opinions as to whether Westfield helped sub. & whether they would recom. it to a friend | Opns. regdg. sincerity of staff. | Opns. regdg. whether social exp at Westfield was more helpful than prvs. schl. exp. | Opns. regdg. whether Westfield had helped S's understand & deal with their pblms. |
|---|---|---|---|---|---|---|---|
| Residential setting | -.007 | -.072 | .258* | .288* | .222* | .195 | .325** |
| School situation | .104 | -.069 | -.117 | .147 | -.033 | -.045 | .182 |
| Work-Hours per week | .030 | -.058 | .191 | .123 | .130 | -.007 | .120 |
| Work-Salary per month | -.014 | .121 | .120 | .206 | .126 | .045 | .123 |
| Self-assessment of adjustment | .104 | -.269* | .131 | .224* | .446** | .028 | .427** |
| Health & physical development | -.021 | .300** | .025 | -.075 | -.071 | .018 | .193 |
| Finances, living conditions & employment | -.019 | .078 | -.053 | -.132 | -.131 | .012 | .082 |
| Social & recreational activities | -.021 | .320** | -.033 | .033 | -.075 | .175 | .215 |
| Courtship, sex & marriage | -.004 | .413** | .077 | -.062 | -.120 | .132 | .169 |
| Social & psychological relations | -.112 | .359** | -.046 | .022 | -.172 | .186 | .090 |
| Personal psychological relations | -.033 | .320** | -.019 | .101 | -.117 | .079 | .188 |
| Morals & religion | -.013 | .292** | .044 | .141 | -.174 | .030 | .190 |
| Home & Family | .018 | .284** | .041 | -.012 | -.185 | .107 | .041 |
| Future: vocational & educational | -.043 | .204 | .043 | -.193 | -.121 | -.009 | .036 |
| Adjustment to school or work | -.066 | .109 | -.188 | .011 | -.179 | .118 | .056 |
| Curriculum & teaching procedure | -.045 | .215 | -.020 | -.167 | -.242* | .152 | .103 |

* Significant at .05 level

** Significant at .01 level

Although overall correlations did not reject hypothesis II, positive correlations significant at the .01 level were found between the following variables:

a) opinion of S's regarding sincerity of staff during treatment and self assessment of post-treatment adjustment.

b) opinions of S's regarding whether Westfield had helped them understand and deal with their problems during treatment and residential setting at the time of survey.

c) opinions of S's regarding whether Westfield had helped them understand and deal with their problems during treatment and self-assessment of post-treatment adjustment.

d) emergence of feelings of guilt during treatment and post-treatment problems in the areas of health and physical development, social and recreational activities, courtship, sex, and marriage, social-psychological relations, personal-psychological relations, moral and religion and home and family.

Positive correlations significant at the .05 level were found between the following variables:

a) capacity for forming relationships with staff during treatment and residential setting at the time of survey.

b) opinions of S's as to whether Westfield had helped them during treatment and whether they would recommend it for a friend and residential setting at the time of survey.

c) opinions of S's as to whether Westfield had helped them

during treatment and whether they would recommend it for a friend and self-assessment of post-treatment adjustment.

d) opinions of S's regarding sincerity of staff during treatment and residential setting at the time of survey.

A negative correlation significant at the .05 level was found between emergence of feelings of guilt during treatment and self-assessment of post-treatment adjustment.

Hypothesis III stated: There were no significant correlations between institutional circumstances during treatment and adaptative at the time of survey.

To test this hypothesis Pearson Product-moment correlations were applied comparing independent variables of:

a) type of residential setting during treatment

b) type of school setting during treatment

c) type of therapy exposed to

d) peer interaction and influence

e) community involvement during treatment

f) length of treatment

with previously stated dependent variables.

The correlations of institutional circumstance variables and adaptation variables are presented in Table VI.

Table 6

Pearson Product-moment Correlations of Institutional Circumstance Variables and Adaptation Variables N=83

| | Type of residential setting during treatment. | Type of school setting during treatment. | Type of therapy exposed to. | Peer interaction and influence. | Community involvement during treatment. | Length of treatment. |
|---|---|---|---|---|---|---|
| Residential setting | -.022 | .001 | .378** | -.107 | -.104 | -.204 |
| School situation | .141 | .343** | -.002 | .144 | .131 | .086 |
| Work-hours per week | -.152 | -.139 | .227* | -.008 | -.135 | -.206 |
| Work-salary per month | -.122 | -.051 | .171 | -.064 | -.195 | -.175 |
| Self-assessment of adjustment | -.095 | .097 | .004 | -.051 | .044 | -.202 |
| Health & physical development | .008 | .053 | -.154 | -.087 | .015 | .062 |
| Finances, living conditions & employment | .107 | .012 | -.070 | -.022 | .007 | .201 |
| Social & recreation activities | -.002 | -.088 | -.065 | -.069 | -.040 | .182 |
| Courtship, sex, & marriage | -.053 | .031 | -.098 | -.107 | .041 | .171 |
| Social-psychological relations | -.043 | -.108 | -.100 | -.048 | .161 | .279* |
| Personal-psychological relations | .004 | -.093 | -.117 | .028 | .143 | .198 |
| Morals & religion | .062 | -.152 | -.080 | -.109 | .104 | .289* |
| Home & family | -.056 | -.109 | -.032 | -.006 | .180 | .296** |
| Future: vocational & educational | .066 | -.010 | -.121 | -.057 | .012 | .328** |
| Adjustment to school or work | .094 | -.032 | -.053 | -.042 | .045 | .261* |
| Curriculum & teaching procedure | .103 | .001 | -.032 | -.051 | -.012 | .305** |

* significant at .05 level
** significant at .01 level

Overall correlations substantiated the null hypothesis. Correlations positively significant at the .01 level were found for the following post-treatment problem areas and length of treatment:

a) home and family

b) future: vocational and educational

c) curriculum and teaching procedure

Positive correlations significant at the .05 level were found between length of treatment and the following post-treatment problem area:

a) social-psychological relations

b) morals and religion

c) adjustment to school or work.

Additional positive correlations at the .01 level were found between:

a) type and extent of therapy exposed to during treatment and residential setting at the time of survey

b) type of school setting during treatment and school situation at the time of survey.

Type and extent of therapy exposed to during treatment correlated significantly at the .05 level with employment-hours per week.

Hypothesis IV stated: There were no significant correlations between situational factors following discharge and adaptation.

To test the hypothesis Pearson Product-moment correlations were

Table 7

Pearson Product-moment Correlations of Situational Variables Following Discharge and Adaptation Variables N=83

| | Number and type of placements following discharge. | Difficulties experienced in the home school and community following discharge. |
|---|---|---|
| Residential setting | .087 | .409** |
| School situation | .237* | .158 |
| Work-hours per week | -.030 | .137 |
| Work-salary per month | -.010 | .254* |
| Self-assessment of adjustment | .193 | .406** |
| Health & physical development | -.059 | -.278* |
| Finances, living conditions, & employment | -.033 | -.347** |
| Social & recreational activities | -.064 | -.293** |
| Courtship, sex & marriage | -.034 | -.299** |
| Social-psychological relations | -.157 | -.463** |
| Personal-psychological relations | -.101 | -.389** |
| Morals & religion | -.039 | -.408** |
| Home & family | -.088 | -.412 |
| Future: vocational & educational | .035 | -.321** |
| Adjustment to school or work | -.051 | -.267* |
| Curriculum & teaching procedures | -.044 | -.287* |

* significant at the .05 level
** significant at the .01 level

applied comparing independent variables of:

a) number and type of placements following discharge

b) difficulties experienced in the home, school and community following discharge with previously stated dependent variables.

The correlations of situational factor variables following discharge and adaptation variables at the time of survey are represented in Table VII.

Although overall correlations substantiated the null hypothesis, situational factors following treatment were found to relate to adaptation at the time of the survey.

Positive correlations significant at the .01 level were found between difficulties experienced in the home, school and community following discharge and adaptation variables of type of residential setting and self-assessment of adjustment at the time of survey.

Correlations significant at the .05 level were found between the following variables:

a) number and type of placements following discharge and type of school setting at the time of the survey.

b) difficulties experienced in the home, school and community following discharge and employment earnings.

Correlations significant at the .01 and .05 level were found between difficulties experienced in the home, school and community following discharge and problem areas indicated on the Mooney Problem Check List at the time of the survey. Suggested interpretations of these correlations are discussed in Chapter VI.

## Chapter VI

## Conclusion and Discussion

### Hypothesis I

Hypothesis I dealt with the correlations between family ties during treatment and post-treatment adaptation. The data indicated correlations significant at the .05 level between family involvement in therapy and the adaptation variable of residential setting at the time of survey. Family involvement in treatment showed no significant correlation with the other dependent adaptation variables of school and/or work situation, self-assessment of adjustment and problems as indicated on the Mooney Problem Check List.

Family situation prior to admission showed a significant negative correlation at the .05 level with problems of adjustment to school and/or work as measured by the Mooney Problem Check List.

Wardship status at the time of treatment showed some relationship with residential setting at the time of the survey. This correlation, however, along with the correlations of wardship status with other adaptation variables, was not significant.

These findings suggested that children whose families maintained contact and participated in family therapy, tended to be in more stable residential placements at the time of survey.

Findings also indicated an impact of family situation prior to treatment on problems following discharge related to adjustment to school or work.

Overall correlations however did not correlate at a significant

level family ties during treatment with post-treatment adaptation.

Hypothesis II

Hypothesis II dealt with the correlation of suggested measures of adaptation to the institution and measures of modifiability during treatment with adaptation at the time of the survey.

Overall correlations substantiated the null hypothesis that adaptation to the institution and measures of modifiability did not significantly predict post-treatment adaptation.

Specific positive correlations significant at the .01 level, however, were found between the following variables:

a) S's opinions regarding sincerity of staff during treatment and self-assessment of adjustment at the time of the survey.

b) S's opinions regarding whether Westfield had helped them understand and deal with their problems during treatment and adaptation variables of residential setting and self-assessment of adjustment.

c) emergence of feelings of guilt during treatment and post-treatment problem areas of health and physical development, social and recreational activities, courtship, sex and marriage, social-psychological relations, personal-psychological relations, morals and religion and home and family.

Specific positive correlation significant at the .05 level were found relating the following variables:

a) relationship with staff during treatment and residential

setting at the time of survey.

b) S's opinions regarding whether Westfield had helped them during treatment and whether they would recommend it to a friend with adaptation variables of residential setting and self-assessment of adjustment at the time of the survey.

c) S's opinions regarding sincerity of staff during treatment and residential setting at the time of the survey.

No significant correlations were found relating responses to the color system or privilege system and adaptation variables.

A negative correlation significant at the .05 level was found relating emergence of feelings of guilt during treatment with self-assessment of adjustment when surveyed.

It might be hypothesized on the basis of these findings that staff child relationships provide a key ingredient for the modification of behavior patterns and successful treatment of emotionally distrubed children.

Response to the "color system" showed no significant correlation to adaptation variables suggesting that adaptation to the institution did not forecast adequacy in the post-Westfield environment.

A further hypothesis might be made that feelings particularly of guilt not dealt with during treatment were manifested in a number of problem areas following discharge.

Hypothesis III

Hypothesis III was concerned with the correlation between institutional circumstances during treatment and adaptation following discharge.

Consideration of overall correlations substantiated the null hypothesis, however, indicated specific significant correlations between a number of variables.

Correlations significant at the .01 level were found relating the following variables:

a) type of school setting during treatment and school situation at the time of survey.

b) type and extent of therapy exposed to and residential setting at the time of the survey.

c) length of stay and problem in the areas of home and family, future: vocational and educational and curriculum and teaching procedure.

Correlations significant at the .05 level were found relating the following variables:

a) type and extent of therapy exposed to during treatment and hours of employment per week

b) length of treatment and post-treatment problems in the areas of social-psychological relations, morals and religion and adjustment to school or work.

No significant correlations were found between type of residential setting during treatment and post-treatment adaptation, peer interaction and influence during treatment and post-treatment adaptation and community involvement during treatment and post-treatment adapatation.

These findings would lend support to the following interpretation:

1. Students at Westfield who were able to cope initially with a community school or were motivated towards one before residential discharge, adjusted better to school following discharge.
2. Students exposed to extensive therapy programs including individual, group and family approaches adapted better residentially and vocationally following discharge.
3. Beyond a certain length of time residential treatment had a detrimental effect on post-treatment adaptation.

Hypothesis IV

Hypothesis IV dealt with the correlations between situational influences following discharge and adaptation at the time of the survey.

Correlations significant at the .01 level were found between variables measuring difficulties experienced in the home, school and community following discharge and adaptation variables of residential setting and self-assessment of adjustment at the time of the survey.

As was expected most correlations between difficulties experienced in the home, school and community following discharge were significant at the .01 level with problem areas indicated on the Mooney Problem Check List. These findings would indicate main problems areas to be:

1. social-psychological relations
2. home and family

3. morals and religion

4. personal-psychological relations

5. finances, living conditions and employment

Number and type of placement following discharge correlated significantly at the .05 level with school situation at the time of the survey as did difficulties experienced in the home, school and community following discharge correlate with employment earnings at the time of the survey.

These findings, although not significant in an overall sense, would indicate situational factors to be of importance and for the purposes of this study to be the best predictor of post-institutional adaptation.

## Conclusions and Recommendations

Findings of this study indicated a relatively high degree of treatment success measured in terms of successful post-treatment, adaptation of Westfield graduates fourteen years of age and over.

Of questionnaries returned approximately 77 percent of the graduates were living in community placements. The remaining 23 percent were living in institutions for juveniles or adult offenders. Approximately 46 percent of the graduates were enrolled in community schools with the majority (approximately 16 percent) taking diploma or general programs. Approximately 17 percent were not attending school because of employment,,while approximately 19 percent were not working or attending school. Of those working, the majority were working less than twenty hours a week and earning under 200 dollars a month.

Four hypotheses were made in an attempt to relate pre-treatment variables, treatment variables and post-treatment situational variables with adaptation at the time of the survey.

The data gathered suggested the following interpretations:

1. Family involvement in treatment and extent of therapy exposed to was important in successful treatment of emotionally disturbed children at Westfield Diagnostic and Treatment Centre.
2. The impact of family situation prior to treatment was reflected in terms of adjustment at school or work.
3. Staff-child relationships and the child's perceived sincerity of staff and assessment of whether staff helped them understand and deal with their problems was important regarding post-treatment adaptation.
4. Feelings not dealt with in treatment, particularly guilt feelings related to a number of problem areas following discharge.
5. Positive adaptation to the institution did not forecast adequacy in the post-Westfield environment.
6. Students who had community school exposure before leaving the institution tended to adapt better to community school placements following discharge.
7. Beyond a certain length of time institutional treatment had a detrimental effect in terms of later adaptation to the community.

8. The nature of situational factors after discharge were the most predictive of post institutiional adaptation.

Findings indicated that treatment in an institution should be viewed as an enabling step to the external environment and provided support for the following recommendations:

1. Emotionally disturbed children have developmental and behavioral problems in conjunction with unresolved situational conflicts. The up-grading of skills and competence of regional office social workers who deal with the protection of children should be encouraged to enable preventative crisis counseling services in times of situational.
2. Special focus and consideration should be given to post-treatment placement. Inservice training of social workers should provide skills for follow-up services. Greater emphasis should be put on utilization of halfway or group home type placements whereby professional help could be provided until situational stresses and conflict at home have been dealt with in family therapy. Possible establishment of follow-up units within treatment centres should be explored to help prevent the need for readmission of children following treatment.
3. Findings indicating that adaptation to the institutional environment did not forecast post-treatment adaptation. would suggest a need for greater individualization, coordination and specialization of treatment. Research

should be conducted by various institutions in the province to determine which children they are best able to help with a goal of greater coordination of services. Treatment in this field should be coordinated with other regional mental health treatment programs. The staff child relationships and ability of staff to facilitate meaningful contact with the children appeared to be an important predictor of post-treatment adaptation. Staff should be involved in inservice programs of a theoretical and experiential nature to better understand and deal with the needs of emotionally disturbed children. As suggested by Paterson, Sawatzky and Oliva (1972) these programs should be conducted by highly qualified people.

5. Staff role functions should be examined in residential treatment centres utilizing communication labs to ensure effective staff interactions.
6. Research in this area would indicate that children in residential treatment suffer more from character defects as a result of distorted relationships with parent figures or identifications with poor adult models, than internalized conflicts which characterize neurosis. These findings suggest a therapeutic orientation involving "ego supportive" and relationship therapy. It would seem that these children are first and foremost at odds with their environment, and only secondarily at odds with themselves.

7. Coordinated work with families should be emphasized.

## Implications

These findings point to the need for adequate after treatment programs and follow-up. Westfield is oriented to help the child meet certain social demands in a manner hopefully related to his unique needs. His mere presence in such an environment may well increase his effectiveness in adapting; however, if he meets with an intolerable or stressful aftercare situation, his learning to cope is not necessarily sustained. Therefore it is the supportive or stressful mature of the post institutional milieu that appears to be the critical factor in success. An internally-oriented approach to treatment is insufficient suggesting a need to bring the community into the institution whereby social demands on the child can be dealt with through regulated exposure to community experiences.

Some of the findings of this study raise the critical issue of need to focus more specifically on factors associated with developmental level. The limitations of this study did not permit an examination of age related variables nor a focusing on the impact of developmental changes (cognitive and otherwise) which may have a direct bearning on treatment success.

Research is needed to test approaches to residential child care that will be more relevant to the child's level of thinking thereby exploring cognitive complications which may be at the root of problems diagnosed as psychologically based.

Living demands placed upon the child should be researched to determine which demands are appropriate to his level of development.

Study findings emphasizing the significance of staff child relationships suggest a need for greater recognition of the dyadic factors that benefit both child and staff member. Also needed is research focusing on the dynamics of group and family therapy in residential treatment centres for emotionally disturbed children.

Effort is needed to isolate the characteristics that distinguish children admitted to residential treatment centres from the general population. Such research should seek to clarify the predisposing and precipitating factors that lead to institution alization.

Longitudinal studies are needed to examine the "sleeper effects" of treatment.

A comparative study is needed to examine foster homes verses institutional care of emotionally disturbed children.

Considering the severity of the emotional disturbance of children who enter residential treatment centres questions arise regarding their fate after discharge. Professionals want to know if it was possible to help these children, whether their separation from home was warranted, and whether residential treatment is economically defensible. Despite widespread interest in follow-up studies of residentially treated children, however, there exists no standard design for such research. This study represents a limited and transitional step in efforts to answer these questions and link the rigorous ideals of scientific investigation with the sensitive artistry of a psychotherapeutically oriented service.

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# APPENDIX A

## DESIGN OF THE QUESTIONNAIRE

## Questionnaire Design

The questionnaire was designed to measure a number of dependent and independent variables defined for the purposes of examining relationships between pre-treatment, treatment and post-treatment factors and adaptation to the community by the child following discharge from residential treatment.

Dependent variables included:

1. Type of residential setting at the time of survey.
2. Type of school and/or work situation at the time of survey.
3. Self-assessment of adjustment at the time of survey.
4. Problems as indicated by the Form H of the Mooney Problem Check List.

Independent variables for the purposes of this study included:

1. Family ties during treatment and considered wardship status, family situation, as assessed by the subject, prior to admission and family involvement in treatment.
2. Situational factors after discharge, and considered the number and type of placements following discharge and problems experienced in the home, school and community following discharge.
3. Adaptation to the Institution and Individual modifiability and considered response to the "color system", capacity for forming relationships with staff, emergence of guilt feelings for wrongdoings during treatment and utilization and assimilation of treatment objectives as assessed by opinions regarding staff, treatment and school.

4. Institutional circumstances, focusing on type of residential setting during treatment, type of school setting during treatment, type and extent of therapy exposed to peer interaction and influence, community involvement during treatment and length of treatment.

# APPENDIX B

## THE LETTER TO CENTRAL OFFICE OF THE DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT.

Diagnostic and Treatment Centre

Central Office

August 5, 1971

ATTENTION: Mrs. J. Turlock
Filing Room

RE: Placement and responsible workers for children from the Diagnostic Centre

Mr. L. W. Howard of the Diagnostic and Treatment Centre is preparing a study on children who have been in our Centre. It will be necessary for him to contact either the child or worker or both. For this reason we are requesting your assistance in completing the attached form as our records do not provide the information needed.

In the case of a child's wardship being terminated may we be advised of the last worker involved in the case and the last placement of the child.

Thank you for your assistance.

A. G. FRAUENFELD, Director
DIAGNOSTIC AND TREATMENT CENTRE

AGF/jz
Att'd.

# APPENDIX C

## THE GRADUATE'S QUESTIONNAIRE

DIAGNOSTIC AND TREATMENT CENTRE
12320 - 124 Street
Edmonton Alberta

January 6, 1972

Dear Graduate:

Enclosed are two questionnaires concerning your stay at the Edmonton Diagnostic and Treatment Centre and a self-addressed stamped envelope.

We would very much appreciate your answering the questionnaires and returning them to us by January 31, 1972.

The two questionnaires should take you about 15 minutes to answer and will help us help other kids who come to the Centre.

You do not have to give your name unless you would like to. The directions for the Mooney Problem Check List are given on the first page under the headings of first step, second step, and third step.

By telling us how you have been getting along since leaving the Centre and your opinion about the Centre and changes you think should be made, we hope we will be able to better understand and help others who come.

Thank you for your cooperation.

Your friend,

Wayne Howard

WH/pw

SECTION A

Complete each of the following items by choosing one of the choices provided. Circle the letter of your choice.

1. Age now:

   (a) 13 - 14

   (b) 14 - 15

   (c) 15 - 16

   (d) 16 - 17

   (e) 17 - 18

   (f) 18 - 19

   (g) 19 - 20

   (h) 20 - 21

   (i) 21 and over

2. I am:

   (a) single

   (b) married

   (c) widowed

   (d) divorced or separated

3. I was at the Edmonton Diagnostic and Treatment Centre:

   (a) 1966 - 67

   (b) 1967 - 68

   (c) 1968 - 69

   (d) 1969 - 70

   (e) 1970 - 71

4. I am now living:

   (a) on my own without assistance from the Department

   (b) with my mother and father

   (c) with my father

   (d) with my mother

   (e) with relatives other than my parents

   (f) in an adoptive home

   (g) in a foster home

   (h) in a boarding home

   (i) at the Y

   (j) in a group home

   (k) at no permanent address

   (l) in an institution or home for juveniles

   (m) in an institution for adult offenders

   (n) other _____

5. This year I am attending:

   (a) a university or college

   (b) N.A.I.T. or other Institute of Technology

   (c) a matriculation program at high school or junior high school

   (d) a diploma or general course at junior high school or high school

   (e) a vocational program in a regular school

   (f) a modified class

   (g) an opportunity class

   (h) taking correspondence

continued...

5. (i) an institutional school

(j) not attending school because of a job

(k) not attending school nor working

Comments:

6. If not attending school becasue of a job, please state type of work you do and answer the next two questions.

Type of Work: _____

(i) I am working:

(a) whenever there is work available

(b) part-time less than 20 hours a week

(c) part-time between 20 and 40 hours a week

(d) full time, 40 or more hours a week

(ii) I am making:

(a) $200 or under a month

(b) $201 to $250 a month

(c) $251 to $300 a month

(d) $301 to $350 a month

(e) $351 to $400 a month

(f) $401 to $450 a month

(g) $451 to $500 a month

(h) $501 to $550 a month

(i) $551 to $600 a month

(j) $600 or over a month

Comments:

7. I would describe my adjustment after leaving the Dianostic and Treatment Centre as:

   (a) very good in that I have had no serious problems at home, in school, or in the community.

   (b) fair in that I have had serious problems at school but not at home or in the community.

   (c) fair in that I have had serious problems with people in the community but not at home or at school.

   (d) fair in that I have had serious problems at home but not in school or in the community.

   (e) poor in that I have had serious problems in two or more of the above areas.

Comments:

8. Since leaving the Diagnostic and Treatment Centre I have lived in:

   (a) over 5 different places.

   (b) 4 or 5 different places.

   (c) 2 or 3 different places.

   (d) one place

   Please list homes or institutions in order which you have been at since leaving the Centre:

SECTION B

9. While at the Diagnostic and Treatment Centre I was:

   (a) a permanent ward

   (b) a temporary ward

   (c) under non-ward care

Comments:

10. Before I came to the Diagnostic and Treatment Centre my family or guardian were::

   (a) all living together except me and not having any serious problems.

   (b) living together but having serious problems and not getting along very well.

   (c) having difficulties because of the death of one of my parents.

   (d) split up because my parents were separated or divorced and social workers had placed the children in other homes.

Comments:

11. While I was at the Diagnostic and Treatment Centre:

   (a) my parents or guardians did not have any contact with staff at the Centre.

   (b) my parents or guardians talked to staff on the phone but never met with them.

continued...

11. (c) one of my parents came to the Centre a few times to talk to staff.

(d) both of my parents met with staff a few times.

(e) both my parents met regularly with staff.

(f) my whole family met regularly with staff.

Comments:

SECTION C

12. While at the Diagnostic and Treatment Centre, I:

(a) found it easy to be raised colors and got to green or purple quickly and stayed there most of the time.

(b) found it took me a few days to get used to the color system but after that got to green or purple quickly and stayed there most of the time.

(c) found it easy the first few weeks but had trouble after I got used to it.

(d) found it hard to get to green or purple the whole time I was there but I wasn't getting dropped to red or orange before I left.

(e) found it hard to get to green or purple the whole time I was there and was getting dropped to red as much before I left as when I came.

Comments:

13. After I had been at the Centre for a few weeks and did something that I knew I shouldn't, I felt guilty and ashamed of myself:

(a) never

(b) occasionally

(c) most of the time

(d) all of the time

Comments:

14. After awhile at the Diagnostic Centre, I:

(a) got to know most of the staff and could talk about myself and my problems.

(b) got to know at least half of the staff and could talk to those people about myself and my problems.

(c) got to know only a few staff well enough to talk about myself and my problems.

(d) got to know a few staff but couldn't talk about myself nor my problems.

(e) didn't get to know any staff well enough to talk about myself and my problems.

Comments:

15. The reason I came to the Diagnostic and Treatment Centre was because:

(a) my parents or guardians weren't looking after me

(b) I couldn't get along with my parents or guardians

(c) I was expelled from school

(d) I was charged with breaking the law

(e) two or more of the above reasons

Comments:

SECTION D

16. While I was living at the Diagnostic and Treatment Centre, I lived:

(a) in a unit

(b) in a unit and group home

(c) in a unit and a cottage

(d) in a unit, a cottage, and a group home

(e) in a cottage

(f) in a cottage and a group home

(g) in a group home

Comments:

17. When I was at the Diagnostic and Treatment Centre, I attended school:

(a) at an outside school

(b) at the Centre then at an outside school

(c) at the Centre the whole time I was there

Please list outside schools attended:

18. The type of counseling I got at the Centre included:

(a) individual counseling, group sessions and family sessions, in addition to daily programs and activities.

(b) individual counseling, group sessions and daily programs and activities.

(c) individual counseling and daily programs and activities.

(d) daily programs and activities.

Comments:

19. I would describe the effect of the other children I lived with at the Diagnostic Centre as:

(a) bad in that they got me into trouble because I had to do things I didn't want to do.

(b) bad in that we had a bad influence on each other.

(c) no effect because I didn't have much to do with them as we didn't get along very well.

continued...

19. (d) pretty good in that we got along well and they didn't cause me to get into trouble just because they did.

(e) good in that we could understand and help each other with our problems.

Comments:

20. I was at the Centre:

(a) more than 2 times

(b) 2 times

(c) once

Comments:

21. While I was at the Diagnostic and Treatment Centre I participated in community activities outside the Centre:

(a) never

(b) once or twice

(c) occasionally

(d) most of the time

(e) all of the time

22. The total length of time I was at the Diagnostic Centre was:

(a) less than 6 months

(b) 6 months to 1 year

(c) 1 to 2 years

(d) 2 years or over

SECTION E

Each of the statements below is followed by a series of numbers from one to five. These numbers indicate the degree or amount with which you agree or disagree with the item concerned. Read each item, then decide how strongly you agree or disagree with the statement and circle the number to indicate your opinion as follows:

1. I agree strongly
2. I agree
3. Undecided
4. I disagree
5. I disagree strongly

23. The Diagnostic and Treatment Centre helped me with my problems and I would recommend the Centre to a friend who has similar problems.

1 2 3 4 5

24. Staff at the Centre don't really care about the children there

1 2 3 4 5

25. If outside schools were like the school at the Centre, most kids would like school a lot more and learn more

1 2 3 4 5

26. I don't think the Diagnostic and Treatment Centre helped me understand or deal with any of my problems and, therefore, did me more harm than good.

1 2 3 4 5

27. Since leaving the Diagnostic Centre, I feel I have adjusted pretty well

1 2 3 4 5

28. Please circle those items which you feel helped you most while you were at the Diagnostic and Treatment Centre

(a) school

(b) individual counseling

(c) the color system

(d) sports and recreation programs

(e) group sessions

(f) the thinking or sick room

(g) relationships with staff

(h) case conferences

(i) family sessions or meetings with staff and your family

(j) outings

(k) summer camps

(l) rules and discipline

(m) being accepted and listened to

(n) relationships with other kids at the Centre

(o) social functions - parties, talent shows, open houses

(p) craft and shop programs

29. Please comment regarding changes you would like to see made at the Diagnostic and Treatment Centre.

# APPENDIX D

## SELECTED COMMENTS OF CHILDREN

Selected Comments of Children

"I personly think it really is doing or was doing great when I was there. To tell the truth I loved it there. And if you ask me if you change it weel it just wouldn't be the same. I enjoyed answering this and hope I here from you gyes again".

"I was a chief and I had some problems that you could help me with and problems I could only help me and finly stopped being a chief and I am glad".

"No color system two movies a week and later hours to stay out at night".

"I think they should have smoking in the unit and kids should start on yellow when they come in".

"If you change it, you would just spoil the kids you get to think about these things when you get older. It's not a bad place at all".

"More responsibility should be given to the children as they become more mature".

"The centre smartened me up a lot I finally relized that I had to live in this world like everybody else, to work for everything I get and not to give up so easily".

"I'm very thankfull for what the staff has done for me, at the time I thought they were crazy, but now that I look back on it they have heped me out a lot to see what this funny old world is about".

"I think they should foreget about the color sheet and give more freedom".

"Well I used to have a feeling of deep lonliness and did not really and truly understand life".